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Vol. 82, No. 33, July 7, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

'IT IS HEARTENING TO KNOW PHYSICIANS HAVE TAKEN ACTION`

My Dear Colleagues:

In February of this year I asked you to make a personal commitment to meet the health care needs of the unemployed. The response to my Medigram letter has been resounding, and I now write to commend you for your actions.

There has been a flurry of high-level activity on this issue since February. The MSMS House of Delegates passed a resolution urging local medical societies to offer medical care at reduced or deferred payment for the unemployed, and charging MSMS to seek methods to assure the unemployed have access to necessary medical care. An AMA delegation, including Michigan physicians John J. Coury, MD, and Henry M. Domzalski, MD, met with President Reagan to discuss this issue and brief him on the voluntary efforts underway in Michigan. Both the President and Congress have proposed bills to extend health services to the unemployed.

But the pride I feel does not result from state or national level attention to the problems of the unemployed. My pride results from the actions of physicians, as individuals and in groups, who have decided to care for patients despite their ability to pay. The June issue of Michigan Medicine contained an excellent overview of this activity. The more populous counties have emulated the Wayne County model, sponsored by Kenneth J. Ray, MD, to distribute care for the unemployed so that individual physicians would not be deluged. Less populous counties have found the problem can be managed best at the physician's office. In most cases, this means that physicians continue to care for their patients regardless of their ability to pay.

It is heartening to know that physicians across the state have contemplated the problem of health care for the unemployed and have taken action. Your actions renew my pride at being a member of our profession, and reconfirm my belief that the strength of the medical profession is in the doctor-patient relationship. Please accept my sincere thank you for a job well begun.

James H. Tisdel, MD
Immediate Past MSMS President
Chairman, MSMS Humanitarian Services Committee

MSMS PUBLIC AFFAIRS LEADERSHIP CONFERENCE IS OCT 27!

Murphy's Law, or a persistent gremlin, has been working against us lately as we try to alert MSMS members to the date of the coming annual MSMS Public Affairs/Leadership Conference. Whatever you have on your calendar now, please be confident that the correct date is Thursday, Oct. 27, 1983. The location will be Long's Convention Center of Lansing. (The two previous issues of Medigram have not printed the correct dates.) Watch for this important Oct. 27 event!

LEGISLATORS SUSPEND BUDGET DEBATE UNTIL THE FALL

As this Medigram was written, MSMS leaders were watching legislative debate over the 1983-84 fiscal year's budget. The Department of Social Services' portion of the budget, critical to Michigan physicians, still was at issue. Lawmakers were debating whether $43 million in the DSS package should be used for home heating aid for the poor--or for a workfare project favored by the Senate. The legislators were well past their hoped-for summer recess date of June 24 and will reconvene to begin their fall session on Sept. 13. The new budget is to go into effect Oct. 1, and Gov. Blanchard is asking for a total figure of $5.322 billion.

HCFA CONSIDERS DRG REIMBURSEMENT OF PATIENT TRANSFERS

Health Care Financing Administration officials in Washington are developing the method of reimbursement to hospitals for patients transferred between hospitals when the diagnostic related group (DRG) payment system goes into effect. This situation will occur when patients diagnosed and hospitalized at one institution are in need of treatment provided at another hospital. HCFA does not want to pay for the same service twice. The option currently considered would provide for the hospital to which the patient is transferred to receive the full DRG rate. The first hospital would get a perdiem payment based on the DRG rate for the length of stay. A final decision is anticipated shortly. Watch for further details.

MSMS OFFERS SEMINAR TO IMPROVE PRACTICE JULY 21 IN ACME

There is time yet for interested Michigan physicians to register for the Traverse City installment of the MSMS seminar, "Improving Your Practice in Today's Competitive Climate." The date is July 21 and the location is the Grand Traverse Village in Acme. The seminar will include segments on practice management, personnel management, computers in medical practice, communications with patients and marketing the medical practice. Speakers are John Anthony, general manager, MSMS Physician Service Group; Vada L. Davis, MSMS assistant administrator and personnel director; Mert Scholten, MSMS chief of communications, and Gilbert Harrell, PhD, director, Department of Marketing, Michigan State University. A registration form was printed in the June 9 issue of Medigram. Physicians may register now with Donna Farougi at MSMS headquarters, or at the door.

MEDIGRAM

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Editor: Judith Marr

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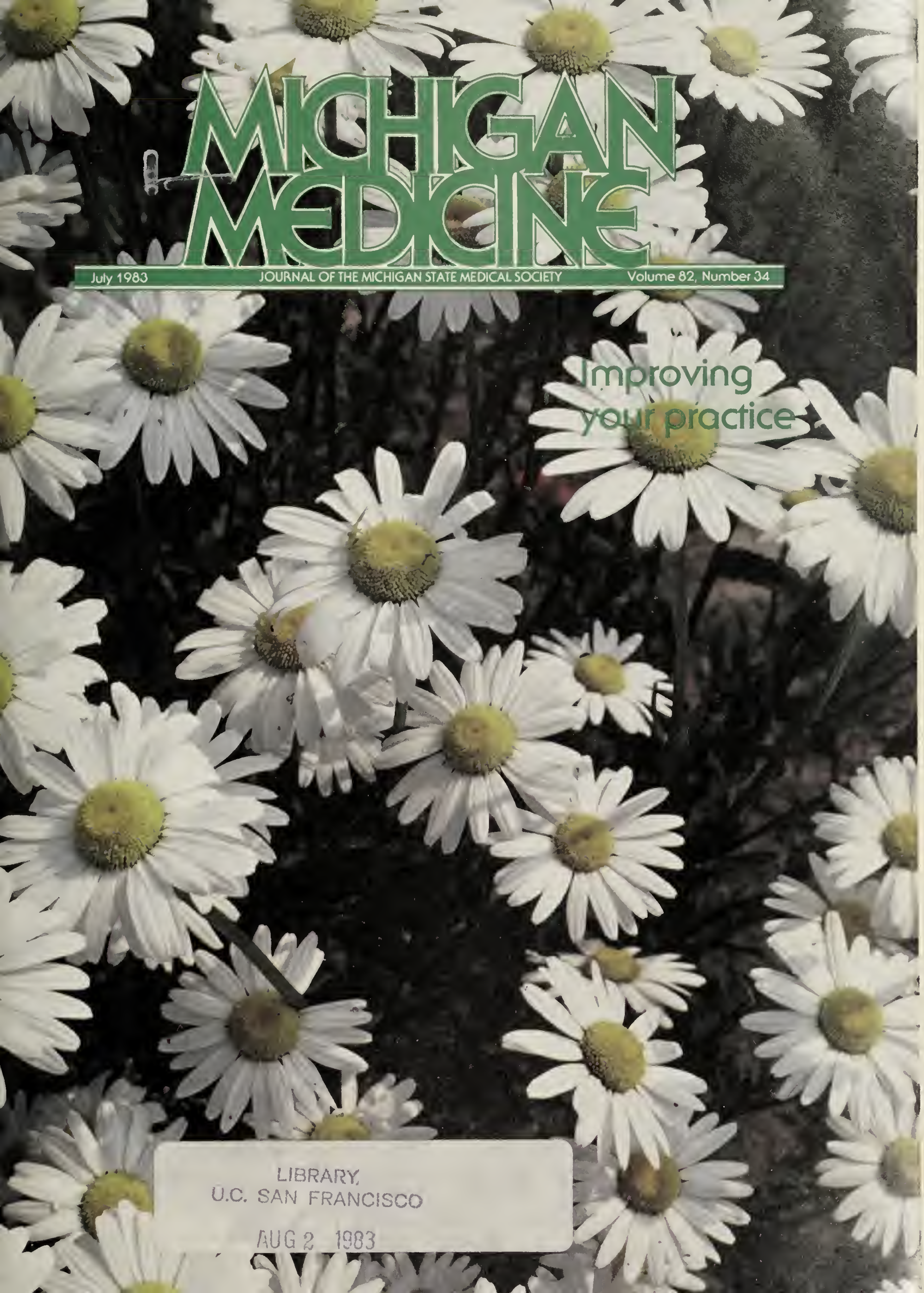

Improving your practice

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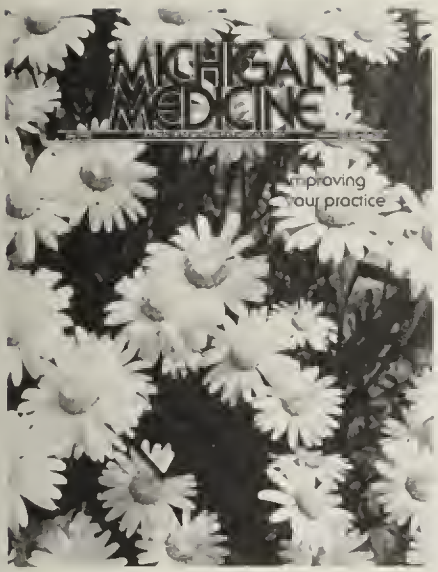

On this month's cover we feature MSMS members at the Lansing seminar, "Improving Your Practice in Today's Competitive Climate." The seminars are the subject of the special report beginning on page 412. **(Photo by Mert Scholten)**

MICHIGAN MEDICINE
July 1983, Vol. 82, No. 34

Special report

412 For those members who have missed the current MSMS road show, *Michigan Medicine* presents a synopsized version in this issue. "Challenge of the 80's: Improving Your Practice in the Face of Today's Competitive Climate" is the title of the MSMS program, which has been presented in six locations around the state this spring. More of the seminars are scheduled this month and later in Traverse City and the Upper Peninsula, and spinoff programs already are under consideration. In this issue are summaries of presentations on marketing techniques and their application to physicians' practices, on computers and when to buy them, and on interviewing new office personnel. Each of these subjects is a major offering in the seminars. If these articles whet your appetite, Doctor, you may contact MSMS headquarters for more details; Carole Eberly, John Anthony and Vada L. Davis.

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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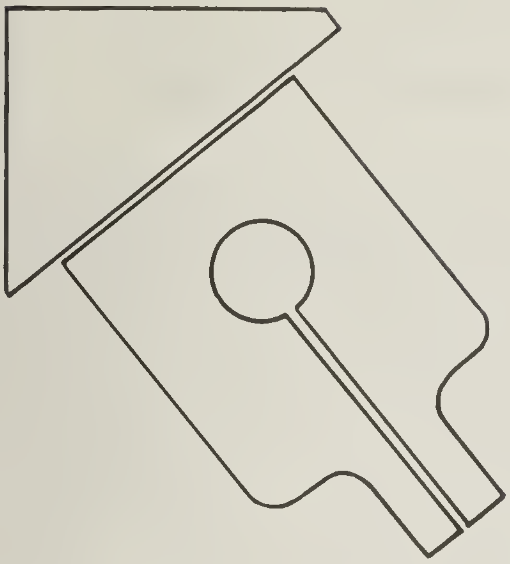
LETTERS



She deserves respect

I was pleased to read of Doctor Shearer's election to the MSMS Council in the May 5, 1983 issue of MEDIGRAM. She was identified as a general practitioner when, in fact, she is a board-certified family physician. This semantic difference is of crucial importance to those of us who believe in, and promote the newest medical specialty. Some of our sub-specialty colleagues badly need the education, and we need the recognition and respect.

Barbara F. Mercer, MD
South Lyon

Instruments, microscopes needed

We wonder if you could see to it that mention of World Medical Relief's needs be included in your Bulletin every few months. This would serve as a reminder to the doctors not to forget us when supplies become available.

We are badly in need of instruments and microscopes to include with shipments to medical missionaries. We feel sure that there are cabinets loaded with instruments no longer being used as so many physicians are no longer performing surgery in the office. The same with laboratory procedures which should free up microscopes for donation. Please remind them that we welcome their drug samples, but none older than 1982, please.

Anything you can do to keep our needs in the limelight through your publications would be greatly appreciated.

God bless you,
Mrs. L.G. Auberlin
President, World Medical Relief

You've just reminded them, Mrs. Auberlin!

Very useful

I would like to commend you on the "Medigram" which I find very, very useful and informative. Keep up the good work.

Eric Ebner, MD
Marshall

Very pleased

On behalf of the members of the Jackson County Medical Society Auxiliary, please accept our sincere appreciation for the extensive coverage given our Auxiliary in the April issue of "Michigan Medicine."

We were very pleased to see such publicity on Cheri Calvelo, state president, as well as Lillian Fields, state legislative chairman.

Louise Hardie
Jackson

'I know who does the work!'

The following letter was mailed to MSMS Immediate Past President James H. Tisdel, MD.

Thank you very much for sending on the 50 year pin. As it turned out, not just the aftermath of a foot operation, but a very acute bronchitis which did not respond to antibiotics kept me here taking care of my wife, so there is no way I could have made it to Dearborn.

Thank you again — some of the best experiences of my years in medicine are related to the contacts I had with MSMS.

Sincerely,
John R. Rodger, MD

P.S. I think I should also say "thank you" to whoever in the MSMS office did the *real* work of mailing out all those pins to those of us who didn't make it! I've been around MSMS long enough to know who does a lot of the work for us!

Physicians must follow exam procedures

My office is responsible for enforcing the Federal Motor Carrier Safety Regulations, which includes a provision that interstate drivers be physically examined each two years to determine whether they meet the minimum physical requirements to drive.

My investigators have recently been running into several cases in which doctors have signed a physical certificate for an unqualified driver and noted on the examination form that he was "qualified only in Michigan." The carrier and driver, however, assumed the signature on the certificate meant (as it should) that the driver was qualified and subsequently used him to drive interstate.

There is currently no physical requirement to drive in Michigan except the abilities necessary to get a license from the Secretary of State. The doctor's signature on the medical examination certificate means the driver is qualified to drive interstate. If he is not qualified, that certificate should *not* be signed.

I have no objection to an entry on the form with the doctor's initials that he is qualified to drive in Michigan, but if the doctor signs the certificate, besides approving a physically unqualified driver, he is taking upon himself some obviously undesired liability for any accidents that might result from the disqualifying physical condition.

I am supplying this information to you for the benefit of those of your members who perform these physicals who may not be aware of the proper procedures for completing them. If you or they need any further information feel free to contact me at the address and phone number listed below.

Sincerely yours,
James C. Gregg
Officer-in-Charge
Region 5, Michigan Division
Federal Highway Administration
P.O. Box 10147; 315 W. Allegan St.
Lansing, 48901
517/377-1866

SPECIAL REPORT

To survive the coming ‘shakeout,’ MDs must target where they want to be

By Carole Eberly
East Lansing

Raymond Kinzel, MD, Lansing, considers a point.

Marketing strategist Gilbert Harrell, PhD, East Lansing, illustrates application of theory to medical practices.

The belief that quality service alone is enough to develop a going medical practice is a horse and buggy concept whose days are gone.

That was the message to physicians attending the MSMS seminar, “Improving Your Practice in Today’s Competitive Climate.” The seminar was held in six sites across the state during April, May and June. Another is planned this month in Traverse City, and spinoff sessions on marketing are in the works.

“Physicians have got to change with the times,” said Gilbert Harrell, PhD, professor of marketing at Michigan State University. “That involves taking a new look at what you’ve got to offer as well as who’s going to buy it.”

Ms. Eberly is a Lansing-area freelance writer.

Harrell was one of several speakers at the seminars which drew approximately 400 MSMS members and other interested persons. Doctor Harrell’s lively, intensive three-hour presentation had physicians looking at their practices in an analytical, business-like manner by using modern marketing methods.

Cobwebbed ideas

One cobwebbed idea Harrell attacked was the belief that offering high quality service at the lowest price in the market would insure business success.

“You just can’t have the highest quality at the lowest price in business,” he said. “You can’t think of one product that fits that description because it doesn’t exist. You just can’t stay in business by doing that.”

Instead, he said businesses must price their products to the markets they’re after.

“The patient will respond favorably to good health care that is reasonably priced,” he said.

Although Harrell said physicians must price themselves in accordance with prices around them— neither giving their services away nor charging such exorbitant fees that no one can afford to buy them— physicians also must be aware of the competition.

Consumers now have more alternatives than ever to traditional physician care including emergency health centers, midwives, weight loss clinics and nutrition centers. The total health field is booming, and a continuation of increased competition is expected in the years ahead.

The problem for physicians, said Harrell, is how to deal with the competition. The answers lie in traditional marketing tools, he said, not in pretending the competition doesn’t exist or will magically go away.

Shotgun approach

"First, there's the shotgun approach," he said.

This is the way many physicians now run their practices, Harrell said. Physicians have not narrowed their markets to certain segments, but rather attempt to hit them all. They aim a shotgun at the whole target in an attempt to hit part of it.

"Second, is the 22 caliber approach," Harrell said.

This is where a physician will aim at certain parts of the market randomly and hit some of them.

However, the most effective means of running a business is to use the concentrated approach, he said.

"This is where the Howitzer comes in," Harrell said.

All ammunition— meaning business resources— is targeted in one direction at one point. It can't miss the target.

"You must determine the needs, wants and values of target markets and develop the practice to provide satisfaction more effectively," he said.

One means of determining needs is to survey the patients, he said. Businesses routinely do market surveys to discover the needs and wants of potential and existing consumers. However, Harrell said he was unaware of any done by physicians.

"Unfortunately, physicians have no idea of the concept of marketing," he said.

He said all problem areas must be looked at and identified before an overall picture can be drawn of the way to proceed in attacking them. In the 1970s, agreed physicians at the seminar, major problems were increased work load, inflation, malpractice suits and government interference. Looking ahead to the remaining 1980s and into the 1990s, physicians labeled competition, reduced patient load, quality of care and physician income declines as the most troublesome areas.

Devising strategy

Once identified, an overall plan or strategy— defined as meeting the enemy in battle under advantageous conditions— must be devised for the problem areas.

In the area of competition, Harrell said, a "shakeout" is going on which ultimately will determine what the role of the physician will be in health care. To survive the shakeout, Harrell said physicians must target where and who they want to be. They must have the technical competence, must be different and better to make it.

The Japanese have developed the shakeout to an art, Harrell said. They go into a depressed sales market, release a product and then make things happen through marketing and promotion.

He gave as an example the camera market, where the Japanese have moved into an area that once belonged to the Americans and Germans. They made their move when people were not buying cameras as they once did. Through successful marketing, the Japanese were able to stir things up in the camera market and capture a large share of it.

The Japanese, through successful marketing, have changed their image as makers of cheap, shoddy merchandise to that of producers of well-constructed, quality products.

An essential business tool in meeting the competition is to look at the market segments, and to isolate them. He labeled market segments as such items as age, income, sex, education, and other demographics. Once a market segment is identified that can be served best by a physician, he or she is in a position to target the practice.

Targeting practices

As an example, Harrell said a physician could target his or her practice toward young females with small children. The physician then could zero in on these patients' wants and needs— immunizations, family planning, back-to-school physicals, nutrition, child rearing information. He suggested workshops could be held for patients, brochures made up for their needs— the ideas are endless in finding tools to meet their needs.

A physician is limited only by his creativity, he said.

Once a business plan is laid out, Harrell said it should be reviewed every two months the first year for alterations. After that, he suggested a quarterly review.

Harrell plunked businesses into four groups which he said apply to physicians as well. There were the stars, the question marks, problem children or sweepstakes; the cash cows and the dogs.

The stars, where everyone wants to be, are those businesses thriving and growing— those at the top.

The question marks are businesses which could either become stars or just fizzle out. The problem children have some areas to be worked on before moving up to stardom. The sweepstakes are businesses that just get swept up into the star category because of creative management and/or being in the right place at the right time.

The cash cows are businesses that have been very successful in the past and are now living off that past wealth or are supporting younger, newer businesses. He cited General Motors as an example.

The dogs are just that— dogs. They are businesses that never made it or that went bad for a number of reasons.

Good businesses are always working toward stardom, Harrell said. He added that a combination of new services (such as equipment, knowledge and referrals) and existing services targeted at specific segments were necessary to reach that category.

To become a star, Harrell said physicians must let go of outdated, traditional approaches to business. Physicians, he said, were allowed that luxury in the past because of the traditional patient-physician role. In other words, the patient had nowhere else to go for health care.

Two approaches

Now there are two approaches left for the physician.

The first is the managerial role where the physician moves things around a bit, changes approaches slightly, puts his plan in order and then goes for it.

The second is the entrepreneurial role which involves a degree of risk. It also calls for creativity and total immersion in the business to make it work.

These are two ways, he said, not only to survival, but also to have a business that becomes a star.

But it all begins with physicians taking the first step by learning what marketing has to offer their practices.

"It's up to you," Harrell said. "You have the power to decide what direction you want to go."

To ensure successful computer operation, start with the right questions

By John Anthony
East Lansing

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STAFF

John Anthony, right, with seminar participant Omero Iung, MD, Lansing.

Doctor Richard Rasmussen, Grand Rapids thoracic surgeon, invited me to his office one day last fall to discuss computers for his medical practice.

"John," he said, "I know where I want to go, but I have no idea how to get there."

Like many Michigan physicians, Doctor Rasmussen was inundated with literature on computers, and needed help to sift through it.

Together we looked at his practice, and decided he could use a computer. His current manual system was stretched to the limit.

Mr. Anthony is general manager of the MSMS Physician Service Group, Inc.

In addition, one of his colleagues in the practice was about to retire. That physician had handled the financial management systems, and none of the other partners was willing to take on that responsibility.

Another major reason we felt a computer system would be a good bet in Doctor Rasmussen's office is that several of the partners had home computers and were familiar with their operation.

We sorted through the literature of several computer companies, visited several vendors, and then made our decision on equipment.

This is a process many physicians are undertaking today. And because of that, I teach a major segment of the MSMS seminars, "Improving Your Practice in Today's Competitive Climate," on physicians' computer-buying decisions.

Physicians must often begin by asking, "What size computer do I need?"

What's the need?

I ask them to back up and determine first whether or not to get an office computer or some form of automation at all.

They must answer these questions initially:

1. Do you have a full-time employee spending more than 60 percent of the workday processing third-party claims and patient bills?
2. Do you spend more than $300 per month on an outside billing service?
3. Do you have a large number of insurance forms due to incomplete or inaccurate information?
4. Do you require more than three business days to complete and mail third-party claim forms?
5. Do you have a turnaround time of greater than 15 days to receive payments from third-party carriers?
6. Do you send out more than 250 statements per month?
7. Do you find that your cash flow varies widely from month to month even though the patient load is stable?
8. Do you frequently receive patient/third-party inquiries about services performed?
9. Do you have a substantial number of patient accounts outstanding over 90 days?
10. Do you frequently receive requests for end-of-year statements?
11. Do you write off many patient accounts as uncollectible?
12. Do you experience a lack of continuity in office routine due to staff turnover?

If the physician answers affirmatively to many of these questions, it may be time to consider having electronic data processing help with the business side of medical practice.

Service bureau?

There are several interim steps that can be taken before actually purchasing an in-house computer. These could include participating with a service bureau and having a service bureau provide many of the tasks that office staff is now falling behind in.

This step can take one of two forms. You can either send information to the service via hard copy and have them complete insurance claim forms and send patient statements or you can have an electronic keyboard and matching cathode ray tube coupled with a modem (a device to send information via the telephone lines). This kind of hookup will allow you to enter data from your office on the service bureau's computers, which in turn will process the information, complete the insurance forms and patients' statements away from your office.

Service bureaus can be a very effective way of aiding you in the processing of information in the office. They allow you to enter the world of electronic data processing without a substantial outlay of capital.

However, if you are still inclined to have an in-house computer system, you must answer the following questions before the actual selection process starts:

How much and what kind of storage is needed on this computer system?

Is your practice small enough that you can make use of one of the floppy diskette systems? Or, because of the nature of the practice do you have to have a hard-disk system that allows more information storage?

The length of time patients stay in your practice, the number of visits they make per year, the types and amounts of insurance forms that need to be completed and the statistical reports needed to manage the practice all will help in determining the size of your storage capacity.

Input

You have to decide how you will be putting information into your computer. Most often this will be done through a keyboard device that appears quite similar to your current electronic typewriter. These are customarily attached to a cathode ray tube (CRT) and most often you will have these at various spots throughout the office. It is not uncommon to find several of these in the business area of a multi-physicians' practice. You may also want to consider having a station at a site away from the business office where medical services are actually performed, i.e. a lab, X-ray, or special procedures area in the medical office.

Output

In terms of output there are several considerations to be made. If you have a small office, you may feel that you can only afford to have one type of printer. In fact, this could very easily suffice for your high-volume activities and your activities that involve a higher degree of quality of print.

Most physicians' offices will have two types of printers, a high-speed dot matrix printer and a slower letter-quality printer. The speed of these printers is not vitally important unless you are sending out hundreds of claim forms each week.

The component that is becoming quite popular in physicians' offices today that enables you to transmit information without having a printed form is the device called the modem. This device is attached to your computer and allows you to communicate quickly via the telephone lines. Having a modem is truly the state of the art in terms of transmission of information.

The future

You will certainly want to consider the needs of your office in the future. Will you be adding physicians to the current staff? Will you be changing the mode of your practice? Will you be adding computer applications such as general ledger, accounts payable, word processing, medical information retrieval, financial review, etc.? The well-designed system will accommodate both the current and future needs of the office.

Now let's talk about the power of the computer, the real guts of the operation that makes everything work. That's called the central processing unit (CPU). This is where you have to make certain that the storage, input, and output capabilities can work in harmony. This, in combination, determines the size of the central processing unit.

Now that you have decided the type and size of the hardware, you have to make determinations on the style of the programming or software. The current group of in-house computers truly are "user-friendly;" in other words, an individual with very limited background in data processing can be trained to use the equipment in a very short period of time.

In order to facilitate this ease of use, however, the software must be designed in such a manner that the average medical assistant can easily operate your data processing system.

Also, the software should be written in a program language that allows easy change when modifications need to be made. You should always have the source of programming available to the medical office in case the individual that you purchase the system from is no longer available.

Correctly operating a data processing installation can greatly aid a physician's office. To enhance the likelihood of success, make sure you ask yourself the right questions.

"If I could get everyone to pay their overdue bills, I could afford to put in a computer to take care of the billing."

SPECIAL REPORT/*Continued*

Did you know, doctor, that it's illegal to ask a job applicant's age?

By Vada L. Davis
East Lansing

What questions are illegal for a physician to ask when interviewing a prospective employee?

In my talk before physicians enrolled at our MSMS competition seminars, that question provokes much buzzing from the audience. And most of the physicians are amazed at how many times they have asked illegal questions of persons seeking jobs in their practices.

For the record, here's the answer: Some of the questions prohibited by law concern national origin, religion, age (except "over 18," or "under 70"), marital status, family planning arrangements, child care arrangements, previous arrests and medical history (unless it affects the applicant's ability to do the job he or she is applying for). The Michigan Department of Labor can provide more complete information about the law in this area.

You *may* say something like, "This job requires some weekend work. Is that a problem for you?" "Would working after 5 p.m. without advance notice be difficult for you to manage?" "Were you ever *convicted* of a crime?"

I open my seminar talk with more questions for MSMS members. In the following article, I ask and answer some of those questions, all of which deal with people management in the doctor's practice.

(Editor's note: Watch for an entire special report on this subject planned for a fall issue of *Michigan Medicine.*)

Ms. Davis is one of the major speakers in the MSMS seminars, "Improving Your Practice in Today's Competitive Climate." She is MSMS assistant administrator and personnel director.

A part of office practice that often is taken for granted is management of the people the physician employs. Medical offices demand employees who have special skills, some learned, some innate. These include people skills — making patients feel at ease, being pleasant to co-workers, asking for payment in a determined, but inoffensive way, dealing with ill and sometimes unreasonable patients; and organizational skills — being sure that charts are in the right place and bills are sent out on time, and discretion — maintaining the confidentiality that is vital to a medical practice.

When you improve your office practice to meet the competition, don't overlook this important area. Here are some questions which may help.

How can I get the best employees for my practice?

Contact community colleges and universities that have medical assistants' courses. Ask for names of current or former graduates in the upper quarter of the class who may be seeking positions.

Employment agencies are useful if you spell out exactly what you need in an employee, and what you are willing to provide in salary and benefits. Screen the applicants the agency sends you. Only you can decide whether the applicant meets the standards you have set for your office.

Newspaper ads are OK, too, but you must do *all* the screening yourself. Ask for resumes sent to a box number. Select only five or six of the most promising for follow-up interviews.

Don't overlook the hospital; keep your eyes open for competent people who may want to get out of the hospital into a private practice.

Avoid hiring relatives, friends (or friends of friends). A good friend (or even your wife) may make a poor employee and it is difficult to discharge such an employee without causing interpersonal problems.

Be sure to check usual salary ranges in your community and make sure yours are competitive.

What questions should I ask to get the information I need in a job interview?

Don't lead the applicant into saying what he or she thinks you'd like to hear. You won't find out much about the applicant that way. Use free-form questions that will force the applicant to talk freely, rather than giving stilted one-syllable answers.

If a question can be answered "yes" or "no," it is generally a waste of time.

You might say, "Tell me about your last job." "What was your typical workday like?" "What did you like best about it?" "What was your greatest achievement in your last job?" "What do you consider your strengths to be in job performance?" "What was your favorite boss like?"

When I call previous employers for a reference, how can I get them to tell me what I need to know?

Ask free-form questions, not answerable by "yes" or "no." Ask about the applicant's strengths and try to get specifics. Explain the job in your office and ask which part would be easiest, which hardest, for this person. Ask "Would you rehire this person?" Most important: Pay attention to hesitations, tone of voice, choice of words, and listen to what is *not* being said!

Weighing the ramifications of personnel management at the Lansing seminar are Gurmail S. Dhaliwal, MD, right, and Donald J. Aiken, MD, left.

Do I need a written job description for each employee?

You need a job description for each position so that duties are clear. The applicant will understand what the position involves and serious misunderstandings can be avoided. It can be used as a training tool, too, and if updated properly can be used again and again as necessary. It can also be used in employee evaluations.

Do I need a personnel policies manual?

A personnel manual is mandatory in a well-run office. It proves that you have office rules applicable to all employees and each one knows what they are. (Give each employee a copy and ask each to sign a statement that they have received it and understand it.)

The manual should include working hours and office hours in detail, paid and unpaid holidays, policies re jury duty, sick leave, vacation, personal time, maternity leave, etc. Mechanisms for job evaluation, salary and merit review, probation and dismissal policies, dress code (are uniforms required?) and rules re personal telephone calls should also be outlined.

Be sure to list the employee benefits you offer. Do you have employer-paid health insurance? dental insurance? life insurance? disability insurance? payment of educational or professional fees? uniform allowance? (If uniforms are required, most offices do provide such an allowance.)

What should be kept in the employee's individual personnel file?

Here are some items which should be contained in the employee's personal file: Job application completed at time of employment; signed acknowledgements of receipt of job description and employee policy manual; salary record; attendance record (including record of vacation and sick leave earned and used); employee evaluation forms and other written records.

The file should be kept in a locked file, preferably in the physician's office or the office manager's files. By law, an employee is entitled to see anything and everything in his or her personnel file on request. Don't put anything in the file that you would not want to have the employee read.

How do you handle dismissal of an employee for cause?

Dismissal of an unsatisfactory employee should be handled privately, in a dignified, unemotional manner. The physician should make a firm decision that dismissal is warranted and necessary and not allow himself to be persuaded otherwise by emotional appeals, hostility, or promises to do better.

The termination interview should take place the last day of the week at the end of the work day. The final paycheck should be prepared, including any amounts due for unused sick leave and earned vacation. Don't give any advance notice (if you are discharging the employee for poor performance), but do give up to two weeks severance pay in lieu of notice if you feel it appropriate. (An already discharged employee won't be an asset to your office for those last two weeks, anyway!)

Be sure to retrieve any office keys in the employee's possession (or change the locks if necessary). Walk with the employee out of the office, making sure that he/she removes any personal items. (Once the break is made, it is better if the employee does not need to come back to the office again.)

Finally, be prepared to get calls from prospective employers concerning the discharged employee, and decide in advance how you will handle them.

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References:
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Is there survival after TEFRA? Yes, says MSMS speaker, if doctors move fast

By Carole Eberly
East Lansing

TEFRA regulations may bring on rationing of care, heard MSMS conference participants in Southfield, and above, Lansing.

Physicians should pull out their hospital contracts and re-read them, experts warned at a recent MSMS seminar on the Tax Equity and Fiscal Responsibility Act (TEFRA).

Under the regulations, scheduled to take effect Oct. 1, physician compensation costs at Medicare facilities are defined as:

1) monetary payments,
2) fringe benefits,
3) deferred compensation, and
4) any other items of value a provider or other organization furnishes a physician in return for the physician's services.

One important exclusion, however, is office space related to the treatment of private patients, and billing and/or collection services.

Stimulated attack

"The exclusion of office space, billing and collection costs stimulated attack by the industry since these items are commonly bargained for in physician compensation arrangements," said Lawrence Manson, a lawyer who covered the technicalities of the regulations for MSMS members at both a Southfield and Lansing seminar. Mr. Manson is with the firm of Wood, Lucksinger and Epstein, Chicago.

He said the exclusion was justified by the government on the grounds that these items are related to a physician's service to his or her patients — not hospital physicians' services to hospital patients.

"Existing physician contracts which include these items in the compensation package should be reevaluated," he said.

Under the act, payments to hospitals are broken into two groups — Part A and B. A is the hospital (provider) services, which is the cost. Part B is the physician services, which are the charges.

Physician services are defined as those which:

1) must be personally rendered to an individual patient by a physician.
2) ordinarily require performance by a physician.
3) contribute directly to the diagnosis or treatment of an individual patient.
4) meet additional requirements in the cases of anesthesiology and laboratory services.

According to Michael Gibson, attorney with MSMS legal counsel Kerr, Russell and Weber, it's important for physicians to work out an agreement with the hospital when their services are rendered to both the provider and individual patient.

He told the group lack of such an agreement could result in both hospitals and physicians not being paid.

Gibson said such an agreement should indicate the time the physician spends providing Part A services, Part B services and services not reimbursed under Medicare, such as fund raising.

"Lack of an agreement will result in the presumption that all hospital (provider) - based physician's services are rendered for individual patients (Part B) and no cost reimbursement will be made under Part A," he warned.

Rationing ahead

Taking a broader look at the regulations, Thomas J. Herrmann, MD, associate dean of clinical affairs, Michigan State University College of Human Medicine, said the nation is in for health care rationing under the act.

"The imposition of limits will destroy the illusion of this country's being able to provide a full range of health care services to all people," he said. "A rationing of health care will become a reality."

Continued on page 422

Ms. Eberly is a Lansing-area freelance writer.

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"... to insure economic survival ... get assigned to a well-run hospital ... (and) organize the hell out of (the) medical staff ..."

He said the challenge for physicians and hospitals is to adapt to the reality of finite resources and still deliver a quality product to those in need.

"We can't be all things to all people," he said.

"Providers' and consumers' judgments about 'who gets what' are going to sharply increase and often be very difficult to reach," he added.

Doctor Herrmann said health care is in for its biggest change since the establishment of Medicare in this country.

"And, frankly, I don't have the vaguest idea of what the long-term impact of this will be," he said.

He compared the implementation of TEFRA with the massive building of interstate highways across the nation in the 1950s. The purpose of the highways was to link the east and west coasts. However, no one foresaw the tremendous impact the highways would have on the train and trucking industries, with one being a loser and one a winner.

Up to now, Hermann said hospitals and physicians have had the same goals— providing the best health care possible, which often meant putting patients in hospitals for lengthy stays and running many expensive tests and treatment programs.

At odds

With TEFRA, however, he said, physicians and hospital administrators could end up at odds.

"The new system has potential for bringing great divisiveness between hospital administrators and physicians," he said.

The new program makes it advantageous for hospitals to have shorter patient stays with the minimum amount of testing done. Keeping patients in hospitals the shortest time while doing as little as is medically appropriate may well be the norm in the future, Herrmann said.

While he warned of the dangers under the new system, Herrmann said it was possible for hospitals to survive and thrive under TEFRA.

Economic survival

He advised hospital-based physicians to do two things to insure economic survival.

First, he said, get assigned to a well-run hospital that has first-class management, first-class administrators and first-class financial officers. He also said the board must be topnotch.

Secondly, he said he'd "organize the hell out of my medical staff," making sure everyone was doing an efficient, professional job.

And he advised physicians to get going now.

"If you wait until this thing hits, you're going to be in trouble," he said.

George Nicholson, a certified public accountant, and partner, Arthur Anderson and Company, underscored the need for hospital efficiency by saying errors tolerated in the past now will be unacceptable. He said a recent study showed an average three to four percent of billings were underreported to the government. In some cases, the error-margin went as high as 10 percent. With the advent of tight money from the government, such errors could spell the demise of many hospitals.

Nicholson said an average of $2 million will be withheld from every hospital in the next three years under the cost-cutting provisions of TEFRA; and only the well-managed facilities will survive.

Under the new program, hospitals will be paid for Medicare costs under a diagnostic related group (DRG) system, where 356 disorders are classified for basic payment. These payments slowly will be brought into a nationwide payment schedule in the next four years.

At the end of four years, hospitals in all parts of the country will be reimbursed the same amount for services performed to patients in a specific DRG. There will be two payment schedules— one for rural and one for urban facilities.

The DRG system was developed as a health services research tool at Yale University in 1969.

Cost answer

Congress approved TEFRA in March as an answer to escalating health care costs. In 1965, the total federal investment in health care was $5.5 billion. In 1982, that number leaped to $93.5 billion.

Other figures show that in 1981, the cost of health care was pegged at $287 billion, or 9.8 percent of the gross national product. This was up 15 percent from the previous year.

The federal government estimates with TEFRA and the DRG system, tens of billions of dollars in Medicare funds will be saved over the next five years.

The regulations apply to all physician services furnished in a hospital or eligible Medicare facility.

Doctor Herrmann blamed the cost containment emphasis now occurring on "natural evolution."

"The current emphasis on cost containment is the evolutionary product of over-specialization, indiscriminate development and application of new technology, increased production of physicians, over-building of health care facilities, faulty reimbursement incentives, and an open-ended national investment in health," he said.

He said the natural reaction was imposition of traditional methods of cost containment, as seen in TEFRA. Doctor Herrmann said the longer term goals of cost containment would be seen in resulting increased competition.

"It's a fallacy that competition won't work in health care," he said.

Doctor Herrmann gave as an example the St. Paul/Minneapolis area which has an abundance of physicians and health care facilities, most of them caught up in such competitive methods as discounting.

"Competition does work," he said. "I've seen it."

But for now, Doctor Herrmann said the new system will bring problems that must be shared by hospitals and physicians. They must work together for the answers.

DIMENSION III

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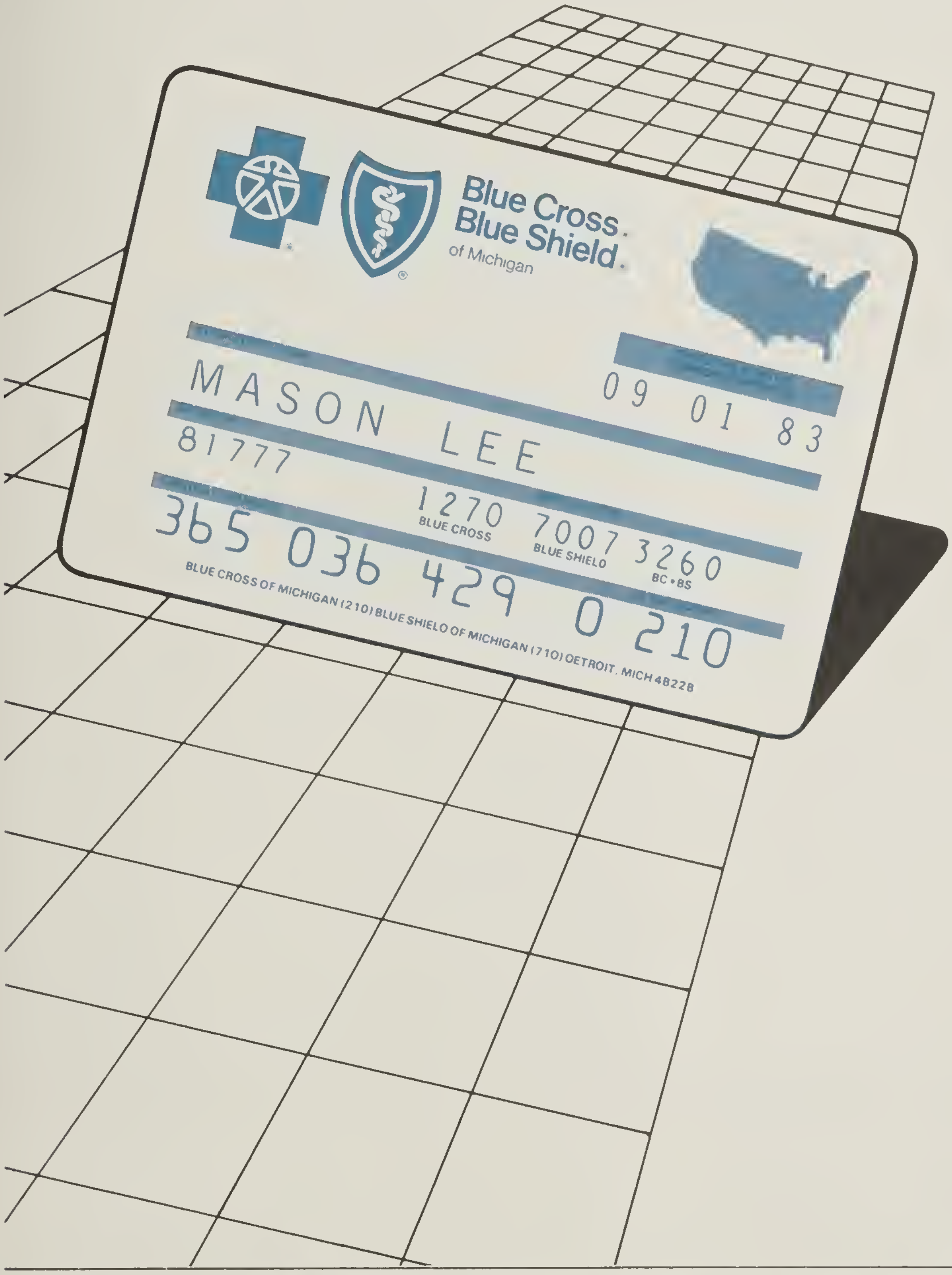
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Supreme Court on track in writing new malpractice rule

By A. Stewart Kerr
Detroit

The Michigan Supreme Court has under consideration a proposed court rule which would permit the Michigan courts to deal specifically and directly with so-called frivolous lawsuits. These are lawsuits commenced that are without merit and/or situations in which the plaintiff or his lawyer made no bona fide attempt to ascertain that the case was meritless. This court rule is proposed of course because of the ineffectiveness of the so-called "countersuits" during the 1970's, the most obvious example of which in Michigan was the *Friedman* case.

Separate opinion

In 1981, the Michigan Supreme Court decided *Friedman, MD* v *Dozorc, et al* against the doctor and in favor of the plaintiff lawyers. The opinion made it crystal clear that no theory short of actual malice would prevail in a Michigan suit against a plaintiff lawyer for having brought a frivolous case.

However, Justice Levin filed a thoughtful separate opinion and suggested that the court itself might promulgate a rule authorizing the trial judge to award the prevailing party actual expenses as "an appropriate measure of deterrence and reasonable compensation of the wronged litigants" to be applicable in those instances where the losing plaintiff or his lawyer "had proceeded without probable cause and for an improper purpose." Such rule would give the prevailing party reasonable attorney fees and damages for loss of income-producing time and for injury to professional reputation. The judge who heard the case would be responsible for this post-trial hearing.

MSMS, amicus curiae in the *Friedman* case, quickly made its interest known to the Supreme Court in the promulgation of such a rule. When the court's chief commissioner invited it, MSMS submitted a draft of proposed language. The Michigan Judges Association also was considering Justice Levin's idea. The MJA also has given language to the Supreme Court, differing somewhat in approach but striving for the same goal of justice.

Mr. Kerr is MSMS legal counsel.

Continued on page 427

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BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm or when angina is refractory to nitrates and or adequate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina but available information is not sufficient to predict with confidence the effects of concurrent treatment especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker but the possibility that it may occur with PROCARDIA alone with low doses of fentanyl, in other surgical procedures or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated the physician should be aware of these potential problems and if the patient's condition permits sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema typically associated with arterial vasodilation and not due to left ventricular dysfunction occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating adjusting and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis mutagenesis, impairment of fertility When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness peripheral edema nausea weakness, headache and flushing each occurring in about 10% of patients transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally the following have been reported muscle cramps nervousness dyspnea, nasal and chest congestion diarrhea constipation inflammation, joint stiffness, shakiness sleep disturbances blurred vision, difficulties in balance dermatitis, pruritus urticaria fever, sweating chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients It remains possible however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate transient elevations of enzymes such as alkaline phosphatase CPK LDH, SGOT, and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66) 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59 to 77 F (15 to 25 C) in the manufacturer's original container

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Please see PROCARDIA *brief summary on adjoining page.*

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* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
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3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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J-9043-4 July 1981

The Supreme Court has put these two proposals side by side in its staff report, here duplicated in full.

MSMS	MJA
1. Grounds. An award for actual costs may be granted to all or any of the prevailing parties when the losing party and/or his attorney initiated, defended or continued with the litigation without probable cause or with malicious motives.	1. Grounds. Any party subject to groundless or vexatious civil litigation wrongfully initiated, defended, or continued may petition the trial judge, after trial, for an award to recover costs incurred. An award may be entered against the party, his attorney, or both, where the trial judge finds by clear and convincing evidence that the losing party or his attorney have proceeded without probable cause and for an impoper purpose.
2. Time for filing. A motion made under this provision shall be filed not later than twenty (20) days after entry of judgment in the underlying cause.	2. Time for filing. A motion for such an award shall be filed within 10 days after entry of judgment.
3. Hearing. A hearing shall then be conducted at a time to be decided by the presiding judge; but not more than thirty (30) days after the motion is filed. The hearing should be conducted by the judge who presided in the underlying cause claimed to have been wrongfully brought or defended. The rules of evidence shall not apply in a hearing for actual costs. All parties may call witnesses to testify, including the parties involved and their attorneys.	3. Hearing. If it appears to the trial court that the motion may have merit, a hearing may be held within a reasonable time at which time the trial judge may hear testimony from the parties, and witnesses, including testimony of attorneys in the case.
4. Decision. Within twenty (20) days after the hearing, the presiding judge shall issue his findings of fact and conclusions of law. The clerk shall notify the attorneys for all parties of the decision of the motion for actual costs. The final determination of the award is in the discretion of the presiding judge.	4. The court shall record its findings of fact and conclusions of law promptly so that an appeal from an award or denial of an award under this rule may be consolidated with an appeal, if any, of the underlying cause.
5. Award. An award under this rule shall be limited to pecuniary loss including: (a) actual attorney fees reasonably incurred in maintaining or defending the proceedings; (b) expenses reasonably incurred in maintaining or defending the proceedings; (c) recovery for injury to the prevailing party's professional or business reputation, if the amount is capable of being calculated with reasonable certainty; (d) loss of income-producing time when a cause of action is based on professional malpractice. The award will be limited to the actual costs incurred after the point at which the action should have been discontinued or liability admitted.	5. Scope of Award. The award may include all fees and administrative charges reasonably incurred, as well as reasonable attorney fees. The award may also include a sum to be paid to a party for loss of income-producing time and injury to professional reputations or business resulting from wrongful action where the trial judge finds such amount is capable of being calculated with reasonable certainty. The award is limited to those costs incurred after the point at which the action should have been discontinued or liability admitted.
6. Appeal. Any appeal of an award shall be consolidated with an appeal on the merits of the underlying cause.	

Proposed changes

The court's staff has synthesized these two proposals into proposed, specific changes to existing Rule 526:

.15 Wrongful use of civil proceedings, award

(a) **Applicability.** A litigant or attorney who takes an active part in the initiation, defense,or continuation of a civil proceeding engages in wrongful use of civil proceedings if he acts without probable cause and for an improper purpose.

(b) **Procedure.**

(1) Motion. Within 10 days after entry of the judgment or order of

Medical Journalism Award

Busharat Ahmad, MD, Marquette, left, chairman of the MSMS Committee on Publications, accepts a special prize for editorial and design excellence awarded *Michigan Medicine* during the 1983 MSMS House of Delegates. Making the presentation on behalf of the Sandoz Medical Journalism Awards program is William Loughran, right, Detroit.

SUPREME COURT/*Continued*

> dismissal in a civil proceeding, a prevailing party may move the court for a determination that an opposing party engaged in wrongful use of civil proceedings.
>
> (2) Hearing. The court shall set a time for hearing additional evidence on this issue. If reasonably possible, the same judge who tried the case or otherwise conducted the proceedings resulting in the entry of the judgment or order shall conduct the hearing and shall conclude it within 30 days after the motion is filed. The prevailing party has the burden of proving
> (A) That the proceedings were terminated in his favor;
> (B) That the opposing party acted without probable cause or for an improper purpose; and
> (C) His damages.
> The court shall file written findings of fact and conclusions of law within 15 days after the hearing is concluded.
>
> (3) Findings. If the court finds that an opposing party or his attorney has engaged in the wrongful use of civil proceedings, the court shall award the prevailing party damages for
> (A) The expense (including reasonable attorney fees) that he has reasonably incurred in maintaining or defending the proceedings,
> (B) Any harm to his professional or business reputation if the amount is capable of being calculated with reasonable probability,
> (C) Any other specific pecuniary loss that has resulted from the proceedings,
> (D) Loss of income-producing time, and
> the court shall enter judgment therefore against the opposing party or his attorney, or both, as the proofs warrant. The award is limited to damages incurred after the point at which the action should have been discontinued or liability admitted.
>
> (4) Appeal. The separate judgment entered on the motion is appealable as of right in the same manner as other final judgments entered by the court. The reviewing court may consolidate an appeal on the merits of the underlying case with an appeal from a judgment on the motion.

The Michigan Judges Association also addressed General Court Rule 111.6 and suggested that it read as follows:

> "If it appears *at any time* that any fact alleged or denied by a pleading ought not to have been so alleged or denied and such fact if alleged is not proved or if denied is proved or admitted, the court may, if the allegation or denial is unreasonable, require the party making such allegation or denial to pay to the adverse party the reasonable expenses incurred in proving or preparing to prove or disprove such fact as the case may be, including reasonable attorney fees."

MJA would delete "at the trial" and substitute "at any time," an excellent suggestion.

Reason to believe

Since then, MSMS has made several additional suggestions to the court concerning the new portions of Rule 526. These changes, technical in nature, would further strengthen such proposed rule.

For example, MSMS proposes that the key phrase (appearing several places) "without probable cause *and* for an improper purpose" be changed to read "or." Elsewhere, MSMS suggests that these actions not be triggered just by "entry of judgment" but include also the words "or order of dismissal" to cover those cases that are so "frivolous" as never to be heard completely through in the trial court. MSMS also suggests that the required degree of proof of the frivolity be reduced from "reasonable certainty" to "reasonable probability."

The proposed new rule is being published in the Michigan State Bar Journal and commentary will be invited for a 60-day period. Opposition to the proposed rule by the so-called plaintiff bar is anticipated. Despite the opposition of this always articulate group, there is substantial reason to believe that the Supreme Court is on the right track and will in fact promulgate a new rule of this general character.

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1983 MSMS House of Delegates photo highlights

The work of the MSMS annual meeting is carried out by House of Delegates' reference committees. All resolutions are assigned to one of the eight committees, which discuss them, and recommend action to the full House. Above, a Reference Committee in session is framed by two interested onlookers.

Below right, 1983-84 MSMS President Donald K. Crandall, MD, is sworn into office by MSMS Secretary Robert M. Leitch, MD.

Below left, retiring MDPAC Board Chairman Thomas C. Payne, MD, Lansing, right, shows off his parting gift to MSMS Director (Councilor) Justin L. Sleight, MD, also of Lansing. The MDPAC board presented Doctor Payne with a framed section of the former Michigan House of Representatives chambers carpet.

All attention focused on the tally of ballots during MSMS elections at the House of Delegates. After all the politicking for officer positions, directorships and AMA delegation posts, the delegates' ballots were counted by, from right, B. David Wilson, MD, Kalamazoo; Omero D. Iung, MD, Lansing; MSMS controller Jerry Trahan; Frederick E. Ludwig, MD, Iron River; and Kenneth H. Musson, MD, Traverse City.

MSMS members who graduated 50 years ago from medical school received their pins and recognition before the full House of Delegates, as is customary. But Immediate Past MSMS President James H. Tisdel, MD, right, made a special "house call" to deliver a pin to H. Maxwell Golden, MD, Flint, who was unable to attend the annual meeting due to illness.

VIPs at the 1983 MSMS annual meeting included, from left, incoming President Crandall; new Director (Councilor) Marguerite Shearer, MD, Ann Arbor; Board of Directors (Council) chairman Thomas R. Berglund, MD, Portage, and new President-elect Louis R. Zako, MD, Dearborn Heights.

MSMS Annual Scientific Meeting puts you in touch with high tech

It's a challenge, says East Lansing internist David R. Rovner, MD, to prepare a group of presentations of benefit to physicians and of good general knowledge.

That is why, says Doctor Rovner, he has taken on the chairmanship of the 1983 MSMS Annual Scientific Meeting. The meeting is planned this year for Nov. 15-16-17 at the Hyatt Regency Dearborn.

Key objectives of his Annual Scientific Meeting Planning Committee, says Doctor Rovner, are to find timely topics for all physicians which will further their continuing medical education.

"We're working to prepare a program dealing with the hot issues of the day," he says.

Doctor Rovner emphasizes that his committee has been very careful to use the feedback from previous meetings, and to pay close attention to what physicians attending those meetings requested.

55 Courses

The actual 55 courses to be presented are honed from the 100 or so suggestions the committee considers each year, with careful attention paid to meeting Category I requirements.

Course subjects this year offer the usual variety, from diabetes to child abuse, from traumatic injuries to helping the troubled employee.

Basic cardiac life support courses again will be offered, as well as the continuing favorites on cancer management, medical genetics, pediatric immunology and infectious diseases, arm pain and dysfunction, the dizzy patient, allergy, dermatology breakthroughs, trauma management, hypertension, low back pain, arthritis and plastic surgery.

The increasing technological sophistication of medical treatment is a large factor in this year's courses, which include those on:

Flow Cytometry
Hyperbaric Oxygen Therapy
Gastrointestinal Scintigraphy
Medical Use of Lasers
Vision
Diagnostic and Therapeutic Interventional Radiology, and
Unique Techniques in Plastic Surgery.

Some of the newer courses include those on:

Evaluation and Management of Infertile Couples
Meeting the Needs of the Aged
The Human Health Effects of Nuclear Weapons
High Quality Care with DRGs
Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal
Anorexia Nervosa
Substance-Abusing Women
Marijuana
Surgery for the Morbidly Obese
The Adolescent Who Doesn't Finish Any Task
Home Health Care for Infants and Children

Hotel setting

The Hyatt Regency Dearborn offers most congenial facilities for the meeting, with its 12-story atrium, wide variety of restaurants, "people-mover" automatic bus connections every five minutes with the Fairlane Shopping Center, and proximity to Greenfield Village and Henry Ford Museum.

MSMS again will arrange luncheons for course participants and late afternoon refreshments.

The exhibit hall, featuring booths by MSMS, affiliated organizations and 75 commercial exhibitors, will be open each day and will serve as the setting for the MSMS-arranged luncheons and refreshments.

The complete list of courses appeared in the June 30 issue of the *Medigram* newsletter, along with the names of course directors and sponsoring organizations.

Registration forms and detailed course information will follow in the September *Michigan Medicine* and September and October *Medigrams.*

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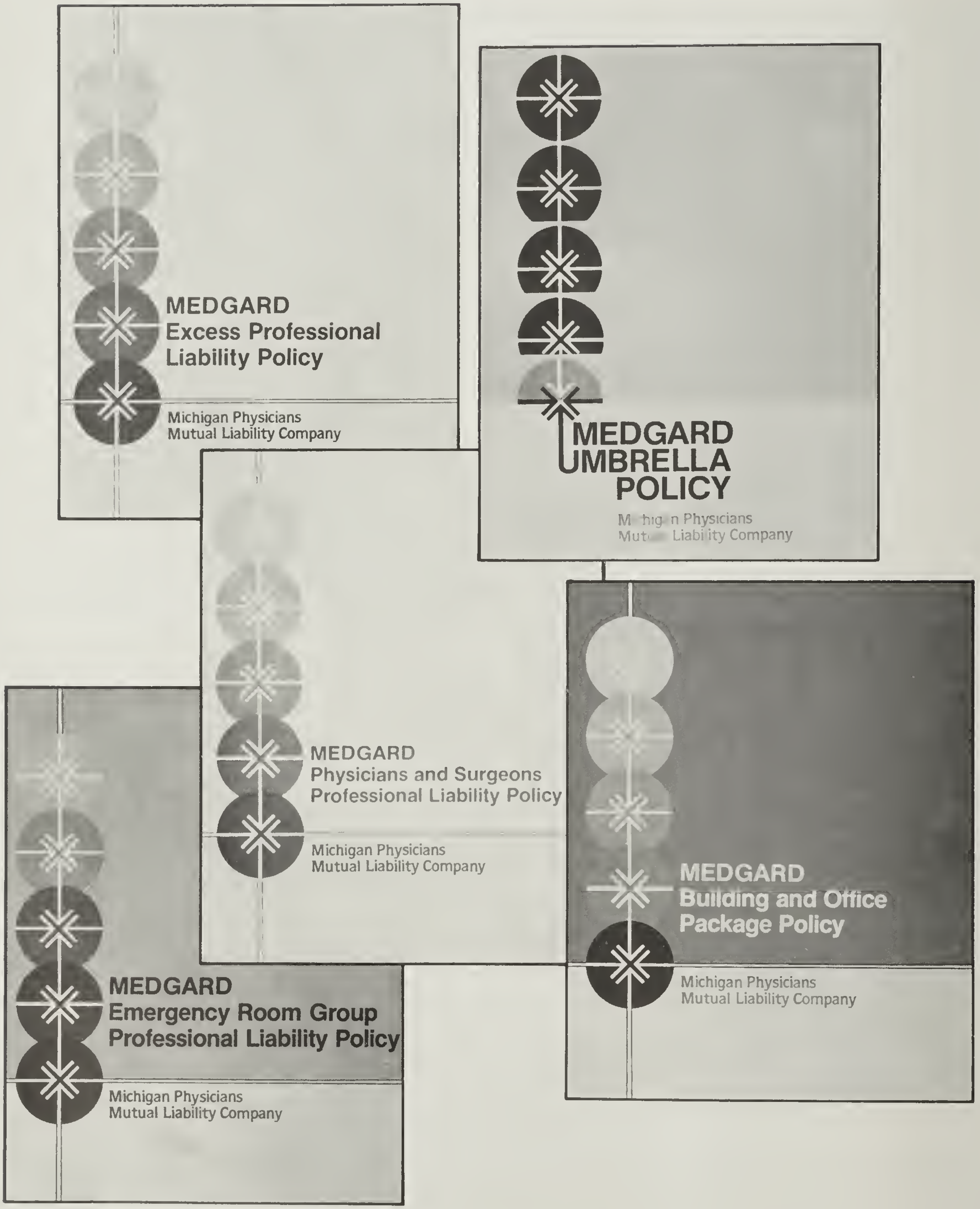

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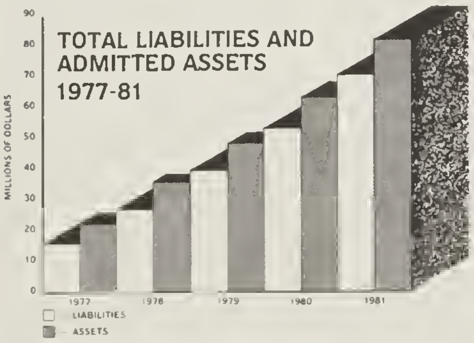
Claims Information Kit

Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our inhouse computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

Stability. Assets of over $88 million back our policies. That's more than $20,000 for each physician insured with us for primary, professional liability. Total surplus of $11.4 million is further evidence of our financial strength and stability. In other words, our policyholders have $3 of equity for every $4 of net premium that we write annually.



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Endorsement. We are the only professional liability company endorsed by the Michigan State Medical Society. The support of MSMS has helped our company grow from an idea in 1975—to Michigan's leading physician insurer. We value our relationship with the members of MSMS and we are proud to display their official seal.

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Board of Medicine disciplinary actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS. Any subsequent actions of the board will be printed in future issues.

- **William L. Cooper, MD**
2267 Mermaid Point NE
St. Petersburg, FL 33703
Date, action taken
By stipulation, Final order: April 13, 1983— reprimand
Alleged Violation:
Refusal to treat an emergency room patient because of patient's failure to pay a prior medical bill to the physician

- **Sherman W. Horn, II, MD**
6346 Valley Trail
Dimondale 48821
Date, action taken
By stipulation, formal reprimand; probation for two years, with reporting; random testing of body fluids to ascertain presence of drugs. (November 9, 1982)
Alleged violation:
drug abuse

- **Raymond V. Jungwirth, MD**
6001 W. Outer Drive, Suite 140
Detroit 48235
Date, action taken
By stipulation, Final order: April 13, 1983— for six months, prescribing and dispensation of controlled substances permitted only in hospital for surgical patients and prohibited in office practice for that term; probation for one year, with semiannual review, maintenance of a controlled substances log; ten hours of drug education; 15 hours of community work with drug and alcohol rehabilitation center.
Alleged violation:
Treating a patient with increasingly larger doses of controlled substances, resulting in alleged addiction

- **Erlinda P. Mercado, MD**
755 W. Big Beaver, Suite 2112
Troy, 48084
Date, action taken
By stipulation, Final order: April 13, 1983— one year probation, with quarterly review of use of controlled substances
Alleged violation:
Inappropriate treatment of a patient for drug dependency with Dilaudid prescriptions.

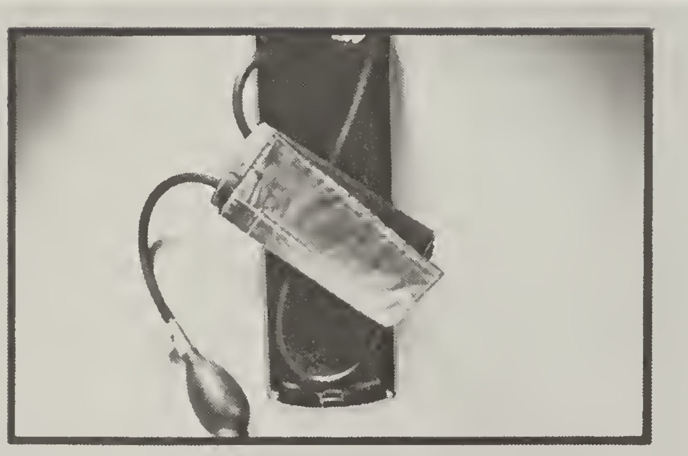
- **Avelino M. Mape, MD**
17277 W. Ten Mile Road
Southfield 48075
Date, action taken
Hearing Opinion: Physician violated the Public Health Code; testimony offered in mitigation, including bookkeeping mistakes by new bookkeeper. Final Order: License suspended 30 days; for three subsequent years, license limited by quarterly review by a CPA of the physician's billing practices, with written findings; after three years of compliance, limited license will automatically be reclassified as unlimited license. April 13, 1983
Alleged violation:
Physician had pled guilty (nolo contendere) to ten counts of Medicaid fraud; Board of Medicine complaint in multiple counts thereon.

- **Dirk Mouw, MD**
1854 South Division Ave.
Grand Rapids 49507
Date, action taken
Board of Medicine Consent Order, February 2, 1983
Reprimand: no further amphetamines to be prescribed
Alleged Violation:
Physician wrote prescriptions for a patient without appropriate Michigan controlled substances license; physician had Drug Enforcement Administration license for Schedule N and 3 controlled substances only.

- **Daleep S. Rao, MD**
P.O. Box 327
107 Chicago St.
Brooklyn, 49230
Date, action taken
By stipulation, Consent Order: April 13, 1983— 2 years probation; specified therapy; written progress reports required quarterly; personal appearances and discussion required quarterly; mental and physican examination required to ascertain whether free from chemical dependency.
Alleged violation:
Attempting to treat hospital patients while under influence of alcohol.

- **Solomon K. Samuels, MD**
205 Borgess Medical Center
1631 Gull Road
Kalamazoo 49001
Date, action taken
Board of Medicine Final Order, January 1983, Reprimand.
Alleged Violation:
Hemorrhoidectomy performed despite ab-

Continued on page 440



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ZYLOPRIM® (allopurinol) IS SIMPLE, EFFECTIVE GOUT THERAPY

Unlike uricosuric agents, Zyloprim® (allopurinol) is clearly the choice for:

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"One recent suggestion is that overproducers of uric acid are more 'appropriately' treated with allopurinol and underexcreters with uricosuric drugs. Such an argument is superficially attractive but may be specious: most patients with gout… may nevertheless be managed perfectly well with allopurinol."[1]

–G. Boss, MD et al

TOPHI, CALCULI, RENAL DISEASE

"… (1) patients with extensive tophaceous disease…; (2) patients with a history of renal calculi… since a uricosuric drug may exacerbate renal stone disease; and (3) patients with significant renal disease… who are unlikely to respond to a uricosuric drug."[2]

–Edward W. Holmes, Jr, MD

For information on adverse reactions, warnings, etc, please see brief summary of prescribing information below.

ZYLOPRIM® (allopurinol)
100 and 300 mg Scored Tablets

INDICATIONS AND USE: **This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.**

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION.

In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Occasional cases of hypersensitivity have been reported in patients with renal compromise receiving thiazides and Zyloprim concurrently. For this reason, in this clinical setting, such combination should be administered with caution.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age:

Zyloprim should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully

"The most important therapeutic measure is the administration of a drug which will block urate synthesis. The agent available at present is allopurinol (Zyloprim . . .) which is very effective and of low toxicity."[3]

—Alfred Jay Bollet, MD

". . . allopurinol treatment appears to retard the progression of renal dysfunction."[4]

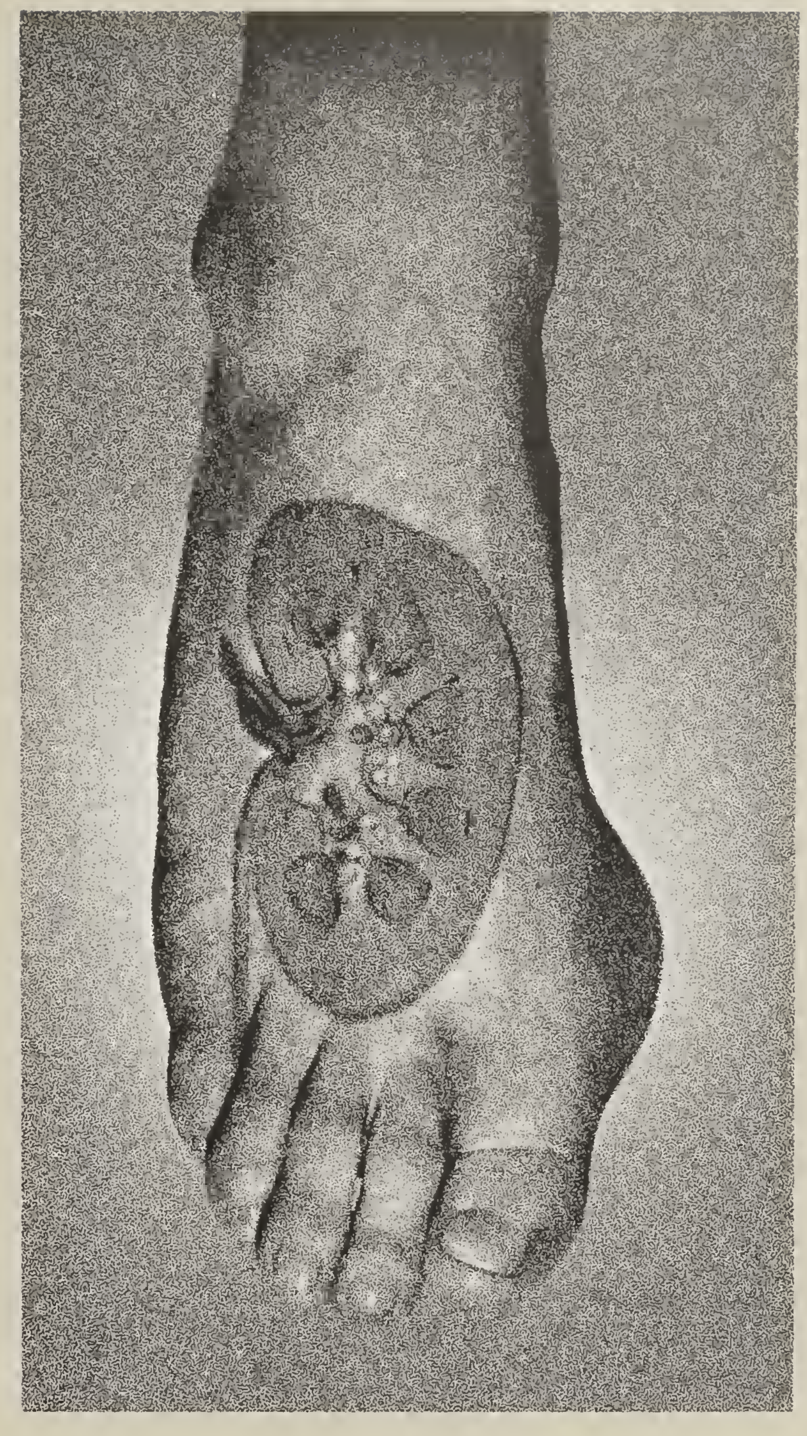
—T. Gibson, MD et al

LOW INCIDENCE OF TOXICITY

"Clinical experience with allopurinol suggests that most patients tolerate this drug well—a finding strongly supported by our data. Undesired or unintended effects of therapy were reported in only 1.8% of 1835 consecutive recipients."[5]

—G. T. McInnes, MD

1. Boss G, et al, quoted by Scott JT: Long-term management of gout and hyperuricemia. *Brit Med J* 281:1164, 1980.
2. Holmes EW Jr: A rational approach to gout. *Drug Therapy* 11:117-124, 1981.
3. Bollet AJ: Prevention and treatment of urate nephropathy and uric acid stones. *Resident & Staff Physician* 28:57-64s, 1982.
4. Gibson T, Highton J, Potter C, et al: Renal impairment and gout. *Ann Rheum Dis* 39:417-423, 1980.
5. McInnes GT, Lawson DH, Jick H: Acute adverse reactions attributed to allopurinol in hospitalised patients. *Ann Rheum Dis* 40:245-249, 1981.



Wellcome

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North Carolina 27709

observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life or oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

Periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:
Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported. The incidence of skin rash may be increased in the presence of renal disorders.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Hepatic: Rare cases of granulomatous hepatitis and hepatic necrosis have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim has been neither implicated nor excluded as a cause of these reactions.

Renal: Rare cases of renal failure have been reported in hypertensive patients who received thiazides and Zyloprim concurrently. Some patients had evidence of hypersensitivity to allopurinol.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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normalities of patient's white cell count, an alleged departure from minimal standards of care.

- **Robert D. VandenBerg, MD**

200 Taft St.
Zeeland 49464

Date, action taken

By stipulation, Final order: April 13, 1983— for six months, dispense, prescribe or administer controlled substances only for endoscopic examinations in-office and as needed for OBGYN patients at two specified hospitals; two year probation, with quarterly reporting and controlled substances log, 80 hours of continuing medical education, in addition to statutory CME requirements and relating to pharmacology.

Alleged violation:

Excessive prescriptions of Dilaudid for a patient.

- **Adrian Leonard Hubert Verwys, MD**

815 Alger St., SE
Grand Rapids 49507

Date, action taken

Board of Medicine Final Order, January 1983

One year probation; forbidden to prescribe or dispense controlled substances to his immediate family; reprimand

Alleged Violation:

Prescribing controlled substance to a person with whom physician did not have a therapeutic patient relationship, knowing the individual was under the care of another physician.

- **John Eric Zimmerman, MD**

211 Beaumont Place
Traverse City 49684

Date, action taken

Board of Medicine Final Order, February 9, 1983

Reprimand: three years probation, with quarterly reporting.

Alleged Violation:

Altercation with patient; physical assault; obscenities.

- **David P. Wesolowski, MD**

Wm. Beaumont Hospital
3601 W. 13 Mile Rd.
Royal Oak 48072

Date, action taken

Board of Medicine Consent Order, January 4, 1983

Probation for two years. During probation: no controlled substances license; therapy at Ford Hospital; attendance at MSMS meetings of Committee to Assist Impaired Physicians; two meetings a week at Alcohol Anonymous; random blood and urine analyses; etc.

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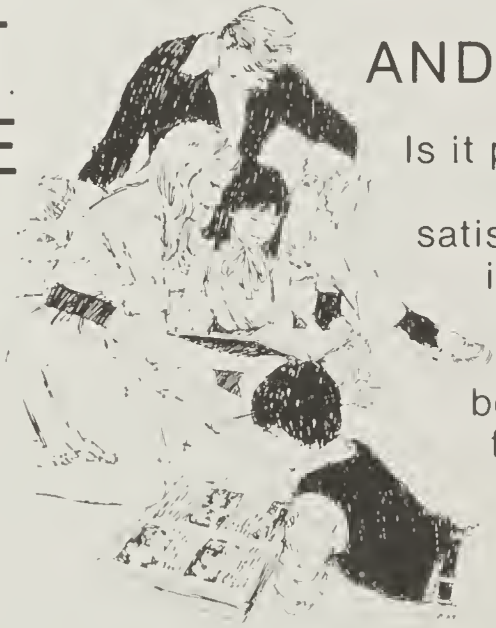

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Medicare fees, use and assignment rates in Michigan

By Miron Stano
Jerry Cromwell
Joseph Velky
Ali Saad
Detroit

What is the degree of competition in Michigan's physician services markets?

That is the primary concern of the HCFA-supported study we report in a series of articles begun in the April issue of *Michigan Medicine*.

Our previous report, "Fees or Use? What's Responsible for Rising Health Care Costs?", described the 15 physician service markets identified for Michigan. It also illuminated the methods used to develop fee and adjusted (for patient bordercrossing) utilization indexes for each of the markets.

In this paper, the same methods have been applied to develop corresponding data for Michigan's Medicare population for 1980. In addition, differences have been examined in assigned and unassigned Medicare claims along with the extent to which physicians accept assignment in each market area.

The Medicare B market basket contains 311 procedures which accounted for 35 percent of all Medicare B charges in 1980. As in the earlier study, these procedures were aggregated with a relative value scale based on average state charges for each procedure. A brief office visit for an established patient was arbitrarily assigned a value of one and the total number of relative value units (RVUs) can be interpreted as the number of "brief office visit equivalents." Average fees per RVU are expressed in both actual dollar (nominal) terms as well as real (adjusted for cost-of-living differences) terms. Three different fee measures are provided: actual charges for RVU; the payment per RVU; and the reasonable charge per RVU.

Two indexes of utilization are shown. One is the actual use per 1,000 Medicare population, and the other is the adjusted use per 1,000 population. This latter index includes "bordercrossing" adjustments for the care that users from one market area receive in other markets, and thus, is a much more reliable estimate of a market's per capita level of use.

The use and fee indexes are shown in **Table 1.** For comparison,

continued on page 444

The authors are, respectively, associate professor, School of Economics and Management, Oakland University; president, Health Economics Research, Inc.; director of Medicare, Health Care Network; and research associate, Blue Cross-Blue Shield of Michigan. This research was supported by Grant No. 18-P-97619/5-01 from the Health Care Financing Administration.

TABLE 1

Medicare (Part B) Fees and Use: 1980

Market Area (Major City)	Actual RVUs/1000 Medicare Population	Adjusted RVUs/1000 Medicare Population	Nominal Charge Per RVU	Real Charge Per RVU	Nominal Reasonable Charge Per RVU	Real Reasonable Charge Per RVU	Nominal Payment Per RVU	Real Payment Per RVU
1. (Bay City)	12061	14152	16.18	10.80	11.91	7.95	9.29	6.20
2. (Petoskey)	11809	12240	16.24	10.76	12.01	7.96	9.43	6.25
3. (Flint)	17685	18841	17.43	11.41	12.66	8.29	10.00	6.55
4. (Traverse City)	11614	13006	15.25	10.26	11.58	7.79	9.09	6.11
5. (Ingham)	14326	13618	16.71	10.72	12.18	7.82	9.56	6.13
6. (Kalamazoo)	14016	13160	15.18	10.04	11.68	7.73	9.24	6.11
7. (Grand Rapids)	11636	12271	15.20	10.26	11.89	8.02	9.36	6.32
8. (Warren)	17583	18629	18.40	11.50	13.78	8.62	10.83	6.77
9. (Marquette)	9718	9829	14.98	10.83	11.17	8.08	8.73	6.31
10. (Muskegon)	14635	15119	15.73	11.03	11.95	8.38	9.38	6.58
11. (Southfield)	27697	18685	19.20	12.01	14.37	8.99	11.31	7.07
12. (Saginaw)	14049	14435	16.23	10.67	11.95	7.86	9.40	6.18
13. (Ann Arbor)	17204	14462	16.97	10.66	13.07	8.21	10.33	6.49
14. (Detroit)	17004	19857	18.88	11.81	13.97	8.74	11.06	6.92
15. (St. Joseph)	10306	10537	14.91	9.88	11.18	7.41	8.83	5.85
State Mean	16154	16154	17.59	11.20	13.15	8.38	10.37	6.61
Market Area Mean	14756	14593	16.50	10.84	12.36	8.12	9.73	6.39

NOTE: Real values are expressed in terms of 1974 Detroit area dollars; the State mean is the average across the State; the market area mean is the average of the 15 market values.

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MEDICARE/*Continued*

the corresponding Blue Shield data (without an index comparable to the Medicare reasonable charge) is given in **Table 2.**

Utilization

Not surprisingly, use by Medicare beneficiaries is much higher by 134 percent for the State than use by Blue Shield recipients for a comparable set of procedures. The patterns, however, are generally similar. For each group of users, there is substantial bordercrossing (as shown by differences between the actual and adjusted measures), with the State's two largest markets, Detroit and Southfield, continuing as the major importers and exporters of care, respectively. There also are significant disparities in use rates with the major metropolitan areas leading the way in each case. The inter-area variation for Medicare, while significant, is less extreme. For example, the highest effective use rate (Detroit) is double the lowest rate (Marquette); while the highest rate (Southfield) for Blue Shield is almost triple that of the lowest (also Marquette). Even if small areas such as Marquette and St. Joseph are treated as statistical anomalies, the disparities across the State are not nearly as striking as those we have found for the Blue

Continued on page 447

TABLE 2

Blue Shield Fees and Use: 1980

Market Area (Major City)	Actual RVUs/1000 BCBSM Population	Adjusted RVUs/1000 BCBSM Population	Nominal Charge Per RVU	Real Charge Per RVU	Nominal Payment Per RVU	Real Payment Per RVU
1. (Bay City)	4808	5538	14.25	9.52	11.26	7.52
2. (Petoskey)	4196	4357	13.48	8.93	10.77	7.14
3. (Flint)	7362	7732	15.06	9.86	11.48	7.52
4. (Traverse City)	4067	4526	12.87	8.66	10.41	7.00
5. (Lansing)	6250	5495	13.54	8.69	10.93	7.01
6. (Kalamazoo)	4695	4345	13.16	8.70	10.49	6.94
7. (Grand Rapids)	4487	4591	12.65	8.54	10.55	7.12
8. (Warren)	7470	8000	15.47	9.67	11.55	7.22
9. (Marquette)	2394	2799	12.56	9.08	10.48	7.58
10. (Muskegon)	4708	4709	13.11	9.19	10.41	7.30
11. (Southfield)	11195	8067	15.32	9.58	11.51	7.20
12. (Saginaw)	5539	5175	13.23	8.70	11.03	7.25
13. (Ann Arbor)	7463	6237	14.16	8.90	10.96	6.89
14. (Detroit)	6715	7931	15.59	9.75	11.30	7.07
15. (St. Joseph)	3282	3766	12.30	8.15	10.22	6.77
State Mean	6893	6892	14.91	9.47	11.30	7.18
Market Area Mean	5642	5551	13.78	9.06	10.89	7.17

NOTE: Real values are expressed in terms of 1974 Detroit area dollars; the State mean is the average across the State; the market area mean is the average of the 15 market values.

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Shield population. Judging from use rates, it would seem that Michigan's Medicare population does not appear to have serious access problems for physician care.

Fees

Because of differences in copayments, deductibles, and the respective assignment rates, direct comparisons between Blue Shield and Medicare fees are difficult. Medicare charges were 18 percent higher than Blue Shield charges. The Blue Shield payment per RVU, however, was nine percent greater than the Medicare payment, exclusive of patient payments. More accurate comparisons on the relative amounts received per RVU by physician would require specific information on the extent to which physicians have been successful in collecting their patients' share.

As for inter-area patterns, the major metropolitan areas, in both sets, typically have the highest nominal charges; while small rural markets have the lowest nominal fees. The highest Medicare nominal charge ($19.20) exceeds the lowest charge ($14.91) by 29 percent, compared to a high-low difference of 28 percent for Blue Shield.

Once cost-of-living differences are introduced, the dispersion in Medicare fees (for all three indexes) is markedly reduced as it is for Blue Shield. For example, only four markets fail to fall within five percent of the market area mean for the real payments index. Three of these exceptions, though, are the State's largest markets (Detroit, Southfield, and Warren) — those with the highest real fees and utilization rates.

Assignment Rates

Out-of-pocket costs for Blue Shield subscribers have been minimal owing to the extraordinary high physician participation rate across Michigan. Charges on non-participating claims amounted to only six percent of total statewide charges in 1980. For Medicare, the assigned component represented 63 percent of all claims and 73 percent of both total charges and payments in 1980. **Table 3** examines the distribution of both assigned and unassigned charges by market area.

Three features are prominent. Detroit and Southfield combined represented 55 percent of all assigned charges and they, together with the contiguous Warren and Flint markets, account for 71 percent.

Second, physicians are much more likely to accept assignment in these and other urbanized areas (although Grand Rapids is an exception). For example, the ratio of assigned to total charges is 84.4 percent in Detroit and does not fall below 76 percent in the greater metropolitan area including Flint, Southfield and Warren.

On the other hand, the level of unassigned billings is nearly as great, and in two cases greater, than assigned charges in the smaller and more rural markets including Petoskey, Traverse City, Marquette, Muskegon, and St. Joseph. Unassigned charges also exceed assigned charges in Grand Rapids, the one significant exception to this pattern. Third, average charges per assigned claim were 57 percent higher than average charges on the unassigned claims suggesting that the volume of services provided to

Continued on page 448

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MEDICARE/*Continued*

patients may be important in the physician's assignment decision.

The study has also found significant differences in assigned rates between specialties. Higher assignment rates are desirable since patient liabilities would normally be reduced as physicians' willingness to accept assignment increases.

Summary

1. There are wide variations in per capita Medicare use rates, even with the adjusted measure we have developed. Use rates in the Detroit-Flint corridor continue to lead the state. The disparities, however, are not as great as we have found for Blue Shield members.

2. Medicare charges per relative value unit (RVU) are 18 percent higher than are Blue Shield charges. We do not have enough data, especially on uncollectibles, to determine whether there are true significant disparities on receipts per RVU.

3. The major metropolitan areas generally have substantially higher fees than other, especially the small rural, areas. After taking into account cost-of-living differences, the disparities are greatly reduced, although the Detroit-Flint corridor still has somewhat higher real fees than the rest of the state.

4. Medicare assignment rates vary widely, from a low of 44 percent (as measured by the ratio of assigned to total charges) in both Petoskey and Marquette, to a high of 84 percent in Detroit. With the exception of Grand Rapids, the rates are generally much higher in urbanized than in smaller and more rural markets.

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By Sheri W. Greenhoe
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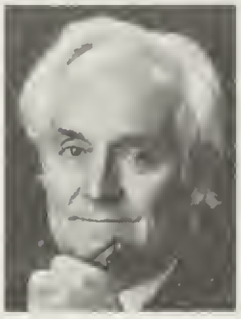

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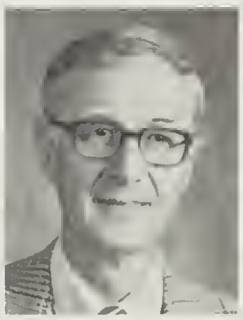

Judge

Stefan S. Fajans, MD, director of the Michigan Diabetes Research and Training Center, has been named U-M's Henry Russell Lecturer for 1983. The lectureship is the highest honor the University can bestow on a senior faculty member. . . . Physician recipients of the U-M Medical Center Alumni Society's distinguished service awards are **John W. Henderson, MD, PhD,** and **Muriel C. Meyers, MD.** Doctor Henderson was cited for his "distinguished educational and professional leadership and his compassionate concern for both patients and students." Doctor Meyers was recognized for her "dedicated service as an educator and administrator and her rare combination of scientific discipline and human warmth." . . . **Richard D. Judge, MD,** Ann Arbor, has been selected by the American College of Cardiology to serve as chairman of its Board of Governors for a three-year term. . . . **Robert M. Heavenrich, MD,** Saginaw, was awarded the Liberty Bell Award for his contribution to the understanding and appreciation of the law in that community during Law Day observances recently. Doctor Heavenrich has served as a delegate to the White House Conference on Children and Youth and as chairman of the MSMS Child Welfare Committee. . . . **Donna H. Powell, MD,** chief of medical service at the Battle Creek VA Medical Center, was honored at a retirement dinner recently that commemorated her more than 30 years of service to veterans. . . . Kalkaska Citizens of the Year are **Doctor and Mrs. Richard Hodgman.** The Hodgmans were selected by the National Trout Festival Board for their dedicated work with the local chapter of the American Cancer Society, and in other civic organizations. . . . **Raymond A. Gadowski, DO,** Franklin Village, has been elected president of the Michigan Association of Osteopathic Physicians and Surgeons, Inc. . . . **Richard E. Dean, MD,** professor and director of surgery at MSU's College of Human Medicine, Grand Rapids campus, has been named president-elect of the Midwest Surgical Association. He was the MSA secretary from 1980-82. . . . **Adalbert Koestner, MD,** MSU College of Human Medicine professor and chairman of pathology, has been named to an eight-member executive panel assembled by the White House Office of Science and Technology Policy to convene an October scientific consensus workshop on formaldehyde. . . . A new in-vitro fertilization program under the direction of **Robert A. Visscher, MD,**professor of OB/GYN at the MSU College of Human Medicine's Grand Rapids campus, has been established at Blodgett Memorial Medical Center, where the state's first test-tube baby program is scheduled to begin this year. . . . **James E. Trosko, MD,** East Lansing, has been selected as a member of the National Academy of Science Committee on Non-Occupational Health Risks of Asbestiform Fibers, and named a consultant on occupational diseases to the NIOSH. . . . **Harold Bowman, MD,** East Lansing, has been reappointed to the executive committee and the medical and scientific committee of the American Cancer Society, and reelected a governor of the American College of Pathology. . . . Psychiatrist **Nelson J. Bradley, MD,** director of Mental Health Services at Detroit's Samaritan Health Center, is first recipient of the National Association of Alcoholism Treatment Programs (NAATP) Outstanding Service Award. The award has been named for Doctor Bradley, to recognize his pioneering efforts in the development of alcoholism treatment. . . . **Orris Ray Yoder, MD,** Ypsilanti, was honored by the local Chamber of Commerce recently for his years of service to that city. He was presented with an "outstanding citizen" award. Doctor Yoder, 89, helped organize the Ypsilanti State Hospital, and has held leadership positions in several medical and civic organizations. . . . **James W. Albers, MD, PhD,** associate professor of neurology at The University of Michigan Medical School, recently was elected to the board of directors of the American Association of Electromyography and Electrodiagnosis. . . . **Philip M. Margolis, MD,** Ann Arbor, received a special recognition award at the recent annual convention of the American Psychiatric Association. The award was given to Doctor Margolis "for outstanding leadership (and) dedication to the APA membership." . . . **Clara Raven, MD,** pioneer in the study of Sudden Infant Death Syndrome, recently conducted sessions on that topic at the Eighth International Convocation on Immunology, Buffalo, and at the International Anglo-American SIDS Research Conference, Baltimore. . . . **Frank B. Walker, MD,** Grosse Pointe Farms, is one of five new vice-presidents of the Greater Detroit Area Health Council, Inc. New physician members elected to GDAHC's Executive Committee are: **Peter A. Duhamel, MD,** Rochester; **Walter G. Parker, MD,** Detroit; and **Fred W. Whitehouse, MD,** Detroit. . . . **Barnett Rosenberg, PhD,** recently received the second annual Cain Memorial Award during the American Association for Cancer Research annual meeting. Doctor Rosenberg, MSU chemistry professor, was cited for outstanding contributions to the discovery of the anticancer activity of cisplatin and related drugs. . . . **Terry M. Silver, MD,** Ann Arbor, recently was appointed to the executive board of the Society of Diagnostic Medical Sonographers, the commission on ultrasound of the American College of Radiology and to the editorial board of *Urologic Radiology*. . . . **Robert P. Kelch, MD,** Ann Arbor, has been named president-elect of the Midwest Society for Pediatric Research. . . . **Bertram Schnitzer, MD,** Ann Arbor, is a new member of the editorial board of the *American Journal of Clinical Pathology*. . . . **Piero Foa, MD,** Professor Emeritus of Physiology at the WSU School of Medicine, was presented the School of Medicine's Distinguished Service Award. Doctor Foa's work and research helped to explain the action of insulin in health and disease.

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CATEGORY I COURSES

Michigan Medicine **each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: July 13, Second Summer Conference: Dermatology for the Practitioner. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, U-M. **For:** Family and general practitioners, internists, pediatricians, and other interested health care professionals. **Cost:** $115. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 8 hours of Category I Credit.

Date: July 18-19, Developing, Marketing, and Managing Conferences: Making It In Tough Times. Location: The Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **For:** Those who will develop/manage conferences and need to know how to do it more effectively and economically, whether for universities, hospitals, professional societies, businesses, or hotels. **Cost:** $345. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: July 21-22, Clinical Dietitian's Update. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education and U-M Hospitals Nutrition Services, Department of Dietetics. **Cost:** $135. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 13 hours of Category I Credit.

Date: July 22-25, Fourteenth Annual Summer Conference — Update for General Practice Ophthalmologists. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150.00. **Contact:** Leslie E. Meissner, Administrative Assistant, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 24-27, 15th Annual Summer Conference of The Michigan Ophthalmological Society — "Surgery for Cataracts." Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150 — physicians; $75 — residents. **Contact:** Leslie E. Meissner, Administrator, Michigan Ophthalmological Society, 302 Eastland Professional Building, Harper Woods 48225, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 25-28, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan, Office of CME, Department of Postgraduate Medicine and Health Professions Education and the Department of Internal Medicine. **For:** Internists and other primary care physicians. **Cost:** $255. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

July 28-29, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: August 15-19, Tutorial on Direct Action Thrusting. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Aug. 20-21, Regional Anesthesia: Anatomy and Techniques. Location: Gordon Scott Hall, Detroit Medical Center. **Sponsor:** WSU School of Medicine Departments of Anesthesia and Anatomy. **Cost:** $260. **Contact:** WSU School of Medicine, Division of DME, 4H DRHUHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: Aug. 26-29, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and The Division of Infectious Diseases, Department of Internal Medicine. **Cost:** $275. **Contact:** Office of CME, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: September 12-16, Basic Muscle Energy Tutorial. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 19-21, Diabetes Update: 1983, Symposium and Workshop. Location: Towsley Center for CME, U-M Medical School, Ann Arbor. **Sponsor:** U-M Medical School Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Division of Endocrinology and Metabolism, Department of Internal Medicine and The Michigan Diabetes Research and Training Center. **Cost:** $245. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 29-Oct. 1, New Perspectives in Cardiac Imaging. Location: Hyatt Regency, Dearborn. **Sponsor:** Professional Education Committee of the Michigan Heart Association, and Council on Clinical Cardiology of the American Heart Association. **Contact:** Eleanor D. Peterson, RN, Program Consultant, Michigan Heart Association, 16310 W. 12 Mile Road, PO Box 160-LV, Lathrup Village 48076, (313) 557-9500. **Approved for:** 17 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Newer Intravenous Anesthetic Agents and Medicolegal Update. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** U-M Medical School, Office of CME, Depart. of Postgraduate Medicine and Health Professions Education, The Department of Anesthesiology and The Michigan Society of Anesthesiology. **Cost:** $125. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 3-7, Advanced Muscle Energy Tutorial (above diaphragm). Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: October 7-9, 5th International Congress of Laser Medicine and Surgery. Location: The Westin Hotel, Detroit. **Sponsor:** Sinai Hospital of Detroit and the International Society of Laser Medicine and Surgery. **For:** Cardiovascular, Endoscopy, General Surgery, Gynecology, Instrumentation/Biomedical Research, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic, Otolaryngology, Photo-Biology, Plastic Surgery/Dermatology, Podiatry, Urology. **Cost:** $345 before 8/30, $380 after 9/1, $300 Post Grad Med Resident. **Contact:** Fifth International Congress of Laser Medicine and Surgery, ℅ Charles B. Slack, Inc., Registration Supervisor, 6900 Grove Road, Thorofare, NH 08086, (609) 848-1000. **Approved for:** 18 hours of Category I Credit.

Date: October 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand and the International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Bldg., 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 1-3, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109, (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: November 7-11, Craniosacral Technique. Location: To be determined. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents basic training in craniosacral palpation techniques. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, MI 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

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DATES AND LOCATIONS

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Amway Grand Plaza Hotel
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Wednesday, September 28, 1983
Bay Valley Inn
I-75 at M-84
2470 Old Bridge Road
Bay City, MI 48706

Thursday, September 29, 1983
Hyatt Regency - Dearborn
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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

July 14-15 — AMA 1983 Regional Membership Meeting, Knickerbocker Hotel, Chicago, contact: AMA, 535 N. Dearborn St., Chicago 60610.

July 21-22 — AMA 1983 Regional Membership Meeting, Sir Francis Drake Hotel, San Francisco, contact: AMA, 535 N. Dearborn St., Chicago 60610.

July 21-24 — MSMS Council Midsummer Meeting, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

July 28-29 — AMA 1983 Regional Membership Meeting, Ramada Renaissance Hotel, Washington, DC, contact: AMA, 535 N. Dearborn St., Chicago 60610.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14). MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherrry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other Meetings

August 7-11 — 1983 Annual Meeting, National Pharmaceutical Association, Westin Hotel, Detroit, contact: James N. Tyson, PO Box 934, Howard University, Washington, DC 20059, (202) 636-7963.

August 19-21 — 1983 Congress, Michigan Association of the Professions, Sugar Loaf Mountain Resort, Cedar, contact MAP, 1407 S. Harrison Road, Suite 350, East Lansing 48823.

August 21-25 — Pharmacy 100 — Anniversary Convention Celebration, Michigan Pharmacist Association, contact: MPA Educational Center, 815 N. Washington Ave., Lansing 48906.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

Sept. 10-11 — "Impact of Lifestyles on Child and Adolescent Health Problems, "cosponsored by the AMA and the Illinois State Medical Society, Chicago Hyatt Regency Hotel, contact: Michael Cherskov, AMA, 535 N. Dearborn, Chicago 60610, (312) 751-5458.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118, (617) 266-9703.

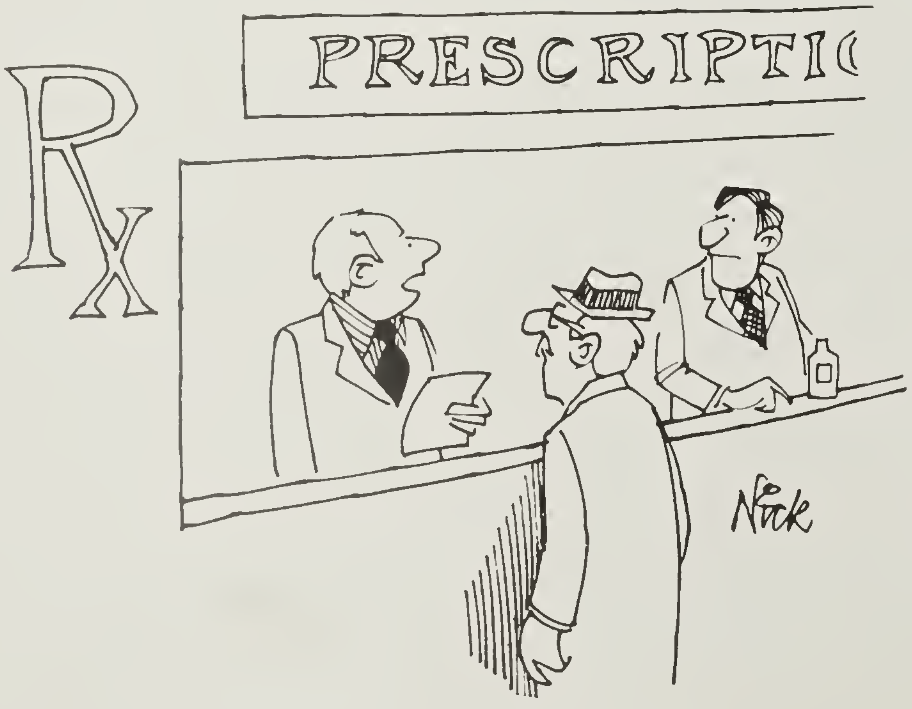
Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209, (703) 528-6405.

November 9-13 — American Medical Women's Association Annual Meeting, Hyatt Regency, Dearborn, contact: Meeting Coordinator, AMWA National Office, 465 Grand Street, New York, NY 10002.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 11 — 1983 Annual Meeting, American Medical Women's Association, Dearborn, contact: Carol Meyers, 465 Grand St., New York, NY 10002, (212) 533-5104.

Nov. 13-15, 1984 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.



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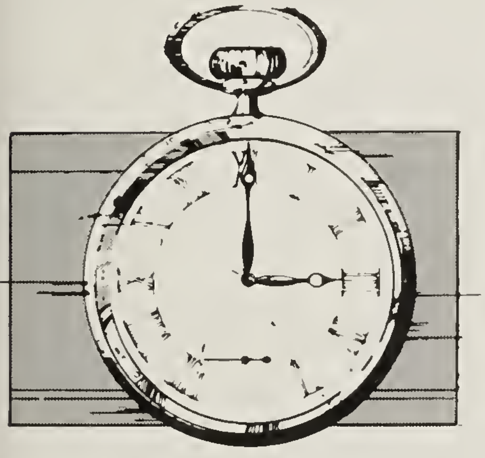

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DUE TO UNEXPECTED ACCELERATION of growth rate, we are looking for several additional highly qualified physicians in the area of Emergency Medicine, Primary Care, Internal Medicine, and Dermatology. Inquiries should be directed to Wilmer M. Rutt, MD, Medical Director, Henry Ford Hospital Fairlane Center, 19401 Hubbard Drive, Dearborn, Michigan 48126.

EMG SPECIALIST WANTED. Stable, highly respected organization which limits its activities to evaluation medicine is in need of American Board Certified Physiatrists with expertise in performing and interpreting electromyographic and nerve conduction studies, on a full or part time basis, in southeast Michigan (Detroit, Flint, Bloomfield). This is an excellent opportunity for those practitioners who wish to eliminate the daily problems of private practice or for those who seek part time forensic work as a supplement to regular income. Work schedules revolve around individual work load requirements and physician-determined availability. Please forward *Curriculum Vitae* to J. C. Day, MD, 14295 East Seven Mile Road, Detroit, Michigan 48205 or call collect at (313) 527-4620.

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DEATHS

Howard B. Barker, MD
Gulf Stream, Florida

Howard B. Barker, MD, formerly of Pontiac, died April 17 at the age of 89. Doctor Barker earned his medical degree from the University of Michigan in 1921. He was on the original advisory committee at Beaumont Hospital, and was the first chief of staff there. He also was chief of surgery for many years. In 1962 Doctor Barker was presented with an oil portrait of himself by the Beaumont Hospital staff. It was hung in the hospital's doctors' lounge.

James G. Christopher, MD
West Bloomfield

James G. Christopher, MD, West Bloomfield pathologist, died April 20. He was 81. Doctor Christopher was a 1929 graduate of the Wayne State University School of Medicine. He was affiliated with Holy Cross Hospital of Detroit, and St. Francis Hospital of Hamtramck. A past president of the Michigan State Pathological Society, Doctor Christopher was a founding Fellow of the College of American Pathologists, and a member of several other specialty organizations.

Fred L. Honhart, MD
Grosse Pointe Park

Fred L. Honhart, MD, Grosse Pointe Park, died May 3. He was 97. Doctor Honhart, once the oldest practicing physician in Michigan, retired from active practice in 1976 at age 90. He earned his MD at the University of Louisville Medical School. Doctor Honhart was a general practitioner at Eastside General, St. Joseph and Providence hospitals. In 1968 he was named "Doctor of the Year" at St. Joseph. As a young man Doctor Honhart was a university-level athletic director, and member of the WWI army medical corps.

Benton A. Schiff, MD
Flint

Benton A. Schiff, MD, Flint surgeon for more than 47 years, died May 5. He was 74. Doctor Schiff graduated from the Wayne State University School of Medicine in 1934, and was past president of the Flint Academy of Surgery. He was on the teaching staff at McLaren General Hospital, St. Joseph Hospital, and Hurley Medical Center. It was Doctor Schiff's responsibility to set up the first Intensive Care unit at Hurley. Doctor Schiff served as a flight surgeon during World War II.

Leon D. Thomas, MD
Detroit

Leon D. Thomas, MD, Detroit, died May 4. He was 58. Doctor Thomas had been a clinical assistant professor of internal medicine at Wayne State University. He earned his MD in 1957 at Howard University Medical School in Washington, DC. Doctor Thomas did his internship at Detroit Receiving Hospital, and his residency at VA Hospital in Allen Park. He was on staff of the electrocardiology department at Southwest Detroit Hospital, and was affiliated with Mercy General and Burton Mercy hospitals.

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This month's column is a continuation of last month's, and both are taken from Doctor Crandall's address on his installation as MSMS president. Doctor Crandall, whose hobby is sailing, took a nautical theme in his address.

PRESIDENT'S PAGE

Voyage of high adventure awaits MSMS 'crew members'

By Donald K. Crandall, MD
MSMS president

Let us spend a few moments to review how MSMS is preparing its members for our voyage by improving their art of seamanship.

The first and most important area of concern is membership. The MSMS Committee on Membership Recruitment and Retention has done much in the past year, so that our membership is at an all time high.

We have done much, but must do more, to increase our membership. We must attract those physicians in practice who have elected not to be part of our crew. We also must attract more students and residents and involve them in our deliberations.

With the voyage ahead it is important that all our members be active. One can choose to sit on the foredeck and sun himself at the risk of being cast overboard with the first swell; or come into the cockpit, grab a line and help the rest of us steer the course.

Streamline skills

With increasing emphasis on costs and competition, much must be done to streamline our office practice management skills. MSMS has responded with Practice Management Seminars, the Physician Service Group, and practical workshops on "Improving Your Practice in Today's Competitive Climate."

We have just published the *Challenge of the '80s* book which is a guide to successful medical practice. These are the tools we will need in the '80s to prepare us for delivery of cost effective medical care, and help us make decisions on the numerous types of delivery systems we will be asked to service.

PROM (Physicians Review Organization of Michigan) has made progress this past year. I view this organization as one that will conduct physician-directed, rather than government-directed, quality review. It also will give MSMS an opportunity to accumulate data on health care costs, so that future decisions can be based on fact and not on political motivation.

Our Bureau of Economics, Medicaid Liaison Committee and the Health Care Delivery Committee continue to evaluate alternative delivery systems and to contribute to programs being developed by others. It is our goal to prepare physicians for the new competitive environment through the activities of these committees.

Our legislation and government relations activities continue to be a major area of concern. Our efforts in these areas, combined with MDPAC activities, result in our ability to educate and inform the legislature of our concerns and the concerns of our patients. As you have heard, we are trying to avoid a new crisis in medical professional liability. A five-part legislative package was introduced in the state legislature this spring. This will help, but much remains to be done. We are now meeting with the Michigan State Bar in an attempt to resolve this ongoing liability problem.

I anticipate that over the next year, we will be meeting with numerous outside organizations in an effort to express the views and concerns of the physicians of Michigan related to a variety of subject matters affecting the practice of medicine. Your support and participation are needed in this effort.

As you can see, much has been done by your medical society to prepare for our voyage. There is still much to do.

Cast off!

Well, mates, I didn't say it would be an easy voyage. We must be prepared. We must understand the territory we will be covering, be flexible in our approach, and develop contingency plans for all eventualities.

We must collect data and be knowledgeable of the issues. We must be prepared to make decisions based on fact and not on impulse.

We must be able to enter the market with a full understanding of its nature and an ability to compete effectively.

The voyage we are about to take has been called a voyage of doom and gloom by some. I don't see it that way.

I see a voyage of high adventure and excitement. I see us facing challenges that have never been faced before.

This is not a voyage for the weak or faint-hearted, but a voyage for those who are well trained, will work together as a crew and not lose sight of our destination. I am confident that, with hard work and your help and leadership, we can bring our whole crew through the voyage successfully.

All aboard who's coming aboard, and let's cast off!

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

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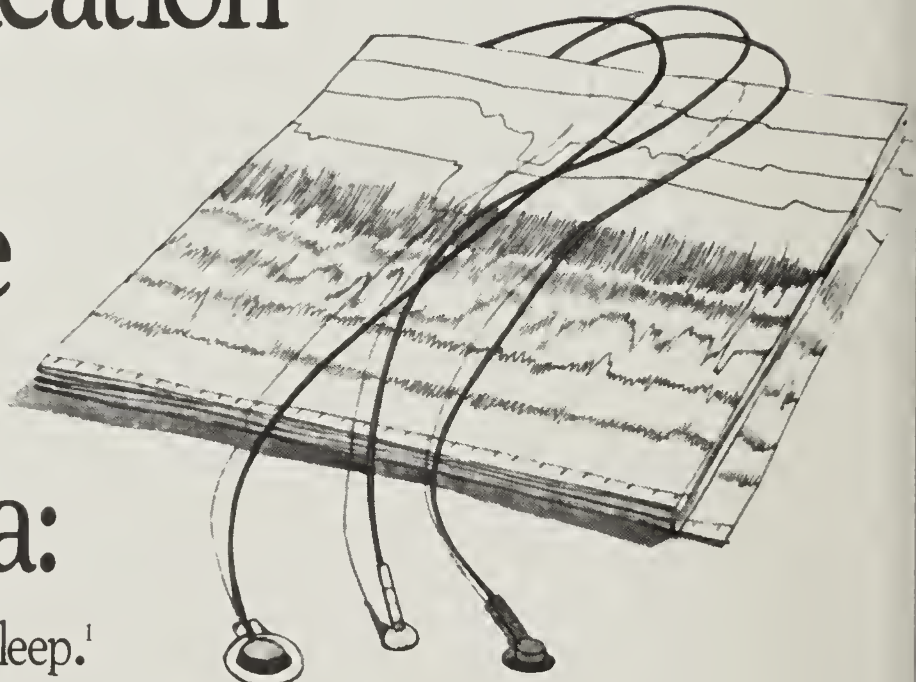

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Vol. 82, No. 35 July 21, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

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MSMS JOINS AMA PILOT ON DRUG ABUSE

MSMS is participating in a statewide effort to prevent prescription drug diversion. Staff member Sherry N. Wellman is the MSMS representative to the interagency task force initiated by Office of Substance Abuse Services of the Michigan Department of Public Health. The task force will coordinate efforts of the Prescription Abuse Data Synthesis (PADS) Project developed by the AMA and US Drug Enforcement Administration. The AMA has named Michigan to participate in the pilot test of this project, which is to provide up-to-date information about prescription drug diversion and to find improved ways to attack the problem.

In its invitation to MSMS to join the task force, the MDPH cited the Macomb County MOP UP Program as exemplifying cooperation by professional organizations. MOP UP, an association of physicians, pharmacists and government representatives, has called for a state prescription drug abuse task force. MOP UP cites Michigan's number one ranking among the states in per capita consumption of Desoxyn, Preludin and Dilaudid, and its second place ranking for consumption of Ritalin and Codeine. MOP UP identified seven major problems related to prescription drug abuse diversion and recommended them for attention by the state. The group said it believes the problem stems from a small number of dishonest physicians and pharmacists in the state who have a minimal chance of being detected and prosecuted.

MSMS DIRECTORS PREPARING FOR MIDSUMMER MEETING

MSMS councilors (directors) were making final preparations for their midsummer meeting July 23 as this Medigram was written. The MSMS Board (Council) was scheduled to meet at Deer Lake, Boyne Mountain. The board was to approve the revised budget for the MSMS 1983 fiscal year, recommend physicians for appointment to the Board of Medicine, hear a status report on the House Special Ad Hoc Committee on Health Care Cost Containment, take action to assist physicians contracting with hospitals, consider a new statement on nurse midwifery, consider a new MSMS section for hospital medical staff members, and hear a progress report on the Physician Review Organization of Michigan.

HOUSE COMMITTEE PURSUES WAYS TO CONTAIN COSTS

The House Ad Hoc Committee Studying Health Care Costs and how the state can act to contain them, will reconvene in mid-August for another of its summer sessions. Legislation to establish preferred provider organizations (PPOs) in Michigan is one of the main objectives of the committee, chaired by Rep. Matthew McNeely. The committee also is looking at capital construction caps, promotion of HMOs, physician supply issues and medical malpractice. At the committee's July 12 meeting, MSMS argued against proposed PPO bill language that would allow Blue Cross Blue Shield of Michigan to limit the number of its agreements with providers.

WASHINGTON CONSIDERS FREEZE OF MEDICARE FEES

The U.S. Senate Finance Committee is proceeding with its plans to freeze physicians' Medicare reimbursement for nine months at limits which were in effect prior to the annual updating on July 1. Under the proposal, charge limits for all MDs' services from Oct. 1, 1983, to July 1, 1984, would remain at the levels applicable during the 1982-83 fee screen year. The committee estimate its action would produce savings of $325 million in fiscal 1984. The Reagan administration is aware of negative action to a freeze from the physician community and has instructed Health Care Finance Administration head Carolyne Davis to meet with an informal physician group to discuss this and other issues. The first meeting will be on July 23.

MSMS 'HOUSECALL' TV PROGRAM TO GO WEEKLY

Lansing television station WFSL (Channel 47) has asked MSMS to step up its live, call-in physician show to a weekly schedule. Reaction has been so good to the semiweekly "Housecall" that the station would like the program to expand. The program airs every other Sunday evening at 5:30 in Lansing, and is carried on cable networks throughout mid-Michigan. Program host is MSMS Chief of Communications Mert Scholten, who reports the weekly schedule will begin in mid-August. Subject of the July 31 program will be dermatological problems, while the Aug. 14 show will take up hay fever and other allergies. Interested viewers may telephone their questions to the on-air physician panel; the telephone is answered by medical assistants.

PPSP ENROLLMENTS GROWING; LARGE SAVINGS PROJECTED

Trends of the first six months of operation show the Physician Primary Sponsor Program in Wayne County may save nine to 10 percent in Medicaid expenditures in its first year. That was the prediction of the Department of Social Services at the July 18 meeting of the PPSP Steering Committee in Detroit. The committee reviewed figures which show an increasing number of enrollments in the program, which now stand at over 21,000. That is up from 10,000 plus in April. If a DSS goal of 100,000 enrollments in the 1983-84 state fiscal year is achieved, projected net savings would reach $3.6 million. The MSMS Liaison Committee, instrumental in development of the PPSP, will continue to keep MSMS members informed.

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Vol. 82, No. 35 July 21, 1983

Vol. 82, No. 36 August 4, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MSMS BOARD HIGHLIGHTS

At its midsummer meeting July 23 at Boyne Mountain, the MSMS Board of Directors took the following actions:

1) Authorized a program to inform Michigan physicians about concepts of joint venturing and contractual relationships with hospitals, stressing possible structures and anti-trust aspects.

2) Directed staff to closely monitor legislative developments regarding preferred provider organizations (PPOs), and named a consulting panel of MSMS members to work with staff. The panel is to report to the Committee on Legislation and Regulations, which in turn will report to the MSMS Board Sept. 14. On the new panel are John A. Feemster, MD, Detroit; Mitchell Rinek, MD, Lansing, and B. J. Woodley, MD, Trenton. They will consult James J. Humes, MD, Detroit, and Charles L. Oppy, MD, Roscommon, chairmen, respectively, of the MSMS Board reference commmittees on health care delivery and legislative policy.

3) Recommended several interested physicians for gubernatorial appointment to the Michigan Board of Medicine.

4) Supported the goals of an AMA Council on Medical Service paper entitled "Payment for Physicians' Services." The paper supports a change in national policy from support of usual, customary and reasonable (UCR) reimbursement policy to an indemnity system. Before taking a position, MSMS will distribute detailed information to all members for their reactions.

5) Endorsed the AMA position that chelation therapy has not been established as an acceptable treatment for coronary or other atherosclerotic disease.

6) Adopted the AMA form for MSMS resident member applications.

7) Heard a progress report on the Physicians Review Organization of Michigan (PROM), which is moving toward contracts to provide review services to the Michigan Education Special Services Association, and to Blue Cross Blue Shield of Michigan. PROM also is preparing to apply for the Michigan PRO contract.

8) Authorized MSMS meetings with specialty societies to discuss the new BCBSM ambulatory surgery initiative program.

9) Opposed any expansion of the scope of practice for chiropractors in Michigan in the face of new legislation introduced to do that very thing; approved a close monitoring of the conversion by third parties to the CPT 4 procedural coding from the Michigan Uniform Procedures Code, and approved a revised budget.

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DOCTOR MINKOW NEW CHAIRMAN, LEGS AND REGS

Frederick V. Minkow, MD, Pontiac hand surgeon, has been named chairman of the MSMS Committee on State Legislation and Regulations, succeeding Wil E. Maldonado, MD, Lansing. Doctor Maldonado is stepping aside after five years of leading the key committee that reviews and recommends legislative and regulatory policy. He will continue as a member of the committee. Doctor Maldonado recently was named vice president for medical affairs at E. W. Sparrow Hospital, Lansing. Doctor Minkow has been a member of the committee since 1978, and also is chairman of the MSMS Task Force on Professional liability.

CAPSULES

Lawrence Sell, MD, is the new medical director, Blue Cross Blue Shield of Michigan. Doctor Sell, who recently was affiliated with Detroit Receiving Hospital, succeeds Armen Shekerjian, MD, who now is medical director of the HMO division of BCBSM. . . . Thomas J. Herrmann, MD, MSU Dean of Clinical Education, is a member of a physician advisory panel to federal Health Care Financing Administration Head Carolyne Davis. The panel is examining health care costs under Medicare and Medicaid and incentives necessary to alter the reimbursement system. . . .MSMS members will have their first opportunity to register for the 55 half-day courses of the 1983 MSMS Annual Scientific Meeting when they receive their copy of the Sept. 8 Medigram. Watch for that important special issue! . . . John McCabe, Blue Cross Blue Shield of Michigan president; Walter Maher, Chrysler Corporation employee benefits and health services director, and Lonnie Bristow, MD, chairman, AMA Council on Medical Services, will speak at the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 in Lansing. Watch for details to come! . . . . Do you have colleagues who haven't joined MSMS and the AMA? You'll have some help this fall in your efforts to persuade them to join their professional societies. Terry Nugent, AMA Membership Division representative, will be in East Lansing Aug. 23 to help coordinate an MSMS/AMA direct mailing to non-member Michigan MDs. The mailing is planned as part of an all-out MSMS membership recruitment campaign. . . . One of the major problems with membership on the Michigan Board of Medicine stands a chance for resolution with HB 4782, introduced by Rep. James O'Neill (D-Saginaw). The bill would immunize physicians from lawsuits resulting from their work as board members, a condition long sought by MSMS as necessary for board duty.

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MICHIGAN MEDICINE

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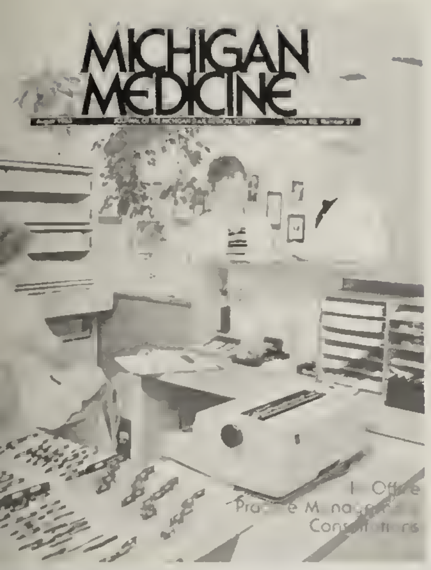

The offices of a Lansing radiology firm set the scene for this month's cover, and point to this month's special report, beginning on page 462. From left, Bonnie Dusseau, RT, Marilyn Ackerman and Robert Carpenter. **(Photo by Kim Kauffman)**

MICHIGAN MEDICINE

August 1983, Vol. 82, No. 37

Special report

462 If your office needs better managing and/or you feel you should be doing better financially, the MSMS Physician Service Group has help. PSG General Manager John Anthony conducts private in-office management consultations as a major service of his organization. A typical consultation is featured this month in our special report, with resulting tips for every physician's practice. The day sheet, monthly financial reports, appointment books, are all scrutinized, and each tells a story to the consultant and all MSMS members looking over his shoulder; Carole Eberly, John R. (Jack) Schweitzer

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Michigan Medicine, the official journal o the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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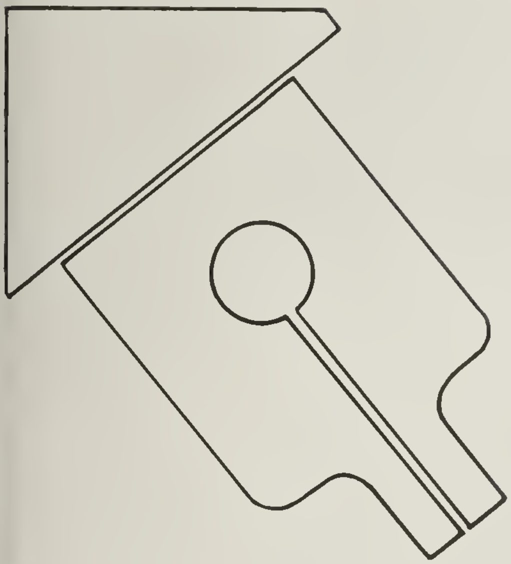
LETTERS



Beautiful publication

Many thanks for the complimentary copy of the recent MSMS publication, "Challenge of the 80s: A Guide to Successful Medical Practice." It is a beautiful publication of which you should be justly proud.

I was most impressed with the content and wish we had the resources to crank out something similar. Nice work!

Sincerely,
Donald F. Foy
Executive Director
Indiana State Medical Association
Indianapolis

To all MDs:

We have reluctantly decided to cease production of Bendectin and have taken all possible steps to ensure that you are the first to know. Here are the factors behind this difficult decision.

As you are aware, Bendectin is the most thoroughly tested product for the relief of nausea and vomiting during pregnancy and has been available to the medical profession worldwide for 27 years. During this time, it has been used successfully by more than 33 million patients. There have been numerous clinical and epidemiological studies demonstrating the safety of the product, regulatory and health agencies around the world and the overwhelming majority of independent experts agree that the available medical evidence does not demonstrate a cause and effect relationship between the use of Bendectin and birth defects.

In spite of this clinical and epidemiological evidence, supported by considerable in-practice experience, significant adverse publicity has continued to surround the product and to undermine patient confidence. There is no sign that scientific evidence and professional support for Bendectin will overcome this highly visible publicity.

Bendectin is a victim of these litigious times and the results of litigation may not always be consistent with scientific facts. Although Merrell Dow prevailed in the initial court case, that judgment did not deter adverse publicity, further trials and the continued filing of lawsuits. On May 27, a jury found in favor of the plaintiff in a second case, but that ruling is now under review by the court. We believe that this second verdict is clearly contrary to the scientific evidence. Unfortunately, the burdens created by litigation and publicity have fallen on physicians, pharmacists, patients and the company.

Despite our decision to cease production of Bendectin worldwide, we are attempting to assure that supplies of Bendectin in the marketplace are sufficient to fill the needs of patients currently completing therapy, there is no reason for these patients to stop medication.

Unavoidably, our decision will create a significant therapeutic gap by the loss of this drug, long valued by physicians in the treatment of nausea and vomiting of pregnancy. It may be that our action will highlight once again the need for our society to reflect upon the effect our nation's current attitude toward litigation is having upon the health care community.

Our medical and scientific resources will remain fully available should you require additional information. If you have any questions, please call 800-543-1970, in Ohio 800-582-3109. If you have any comments, please write to me.

David B. Sharrock
President, Merrell Dow
Pharmaceuticals — U.S.A.
Cincinnati

Put WMR on your list!

Thank you for the complimentary copy of the May, 1983 issue of *Michigan Medicine* that contains a WMR update sent to you by Mrs. Norma Henderson and a reprint of our letter.

We are helping 84 Michigan relief agencies and the Visiting Nurses whose funding has been cut. Since December of '81 through '82 we have given 105,228 lbs. of medical equipment and supplies, valued at $431,945.21. Last year we provided 22,441 prescriptions valued at $335,036.17 to needy 62 and over persons existing on a Social Security check with documented proof of income and banking. We assist U.S. mission type clinics; Appalachia; three drug and alcohol clinic patients and their children; Volunteer Optometric Services to Humanity and Interplast (plastic surgery for deformed children).

Our other programs include medical missionaries in developing countries. A recent letter from Ghana states, "All your medicines were so useful. There is practically nothing in Ghana today to buy. Surgical patients have to bring their own cotton wool, gauze, bandages, medicine, soap and food!! They come to us so our supplies run out quickly. We and they value your gifts." To Haiti we shipped a 50 bed hospital, value $1,130,762.50 and to Poland 14 shipments weighing 283,157 lbs. valued at $7,772,480.06.

We hope that by your publishing this information your physician readers will put us on their donation list.

Irene M. Auberlin
President, World Medical Relief
Detroit

Editor's note: The much-honored and deserving Irene Auberlin (recipient of an MSMS Presidential Citation in 1982) has earned another honor — the President's Volunteer Action Award for 1983. Under her guidance, World Medical Relief now has supplied more than a quarter of a billion dollars' worth of needed materials to missionary doctors, hospitals and clinics worldwide.

MSMS/PSG in-office consultations get down to physician's business

By Carole Eberly
East Lansing

A few extra minutes a day by a physician's staff can mean the difference between a well-run, prosperous practice and a disaster.

"It takes only minutes a day for the office staff to keep accurate, up-to-date records," says John Anthony, MSMS financial specialist. "But the physician must know what's happening exactly when it's happening. If something is wrong, when is the best time to know. Now or five months from now?"

Anthony, who travels around the state helping physicians weed out what's important and what's not in running a financially sound business, said the most important thing in turning a business around is better use of personnel.

When Anthony is called in to make an analysis of a practice, he always picks the busiest day.

"I want to see how everyone performs under fire," he said. "I ask that all financial records be on hand for me. I want the names and hours worked of office personnel. I also need access to how the patient flow is handled, to appointment records as well as forms patients fill out. I watch waiting room procedures. I take a look at how patients are discharged, and how they are asked for payment."

Day sheet

Anthony said the single, most important tool in capturing financial information is the day sheet.

"You can tell a lot of information from this," he said. "But, you've got to pay attention to it."

A few of the questions physicians should ask themselves when looking at the day sheet are:

- Do the figures add up?
- Are the patients paying for services at time of delivery?
- Is there any lost information?

Anthony said if there is lost information to be suspicious of the office operations. There are errors being made either on purpose or through negligence.

He said the day sheet should be totaled and balanced at the end of each day so any errors become apparent immediately.

"That way the physician doesn't have to go back through weeks of figures looking for errors," Anthony said. "That can be time-consuming and frustrating."

Monthly

He said monthly reports should be made on revenues such as office, hospital and lab work, and on expenses such as salaries, fringes and rent. These reports can then be pulled and compared at any time with the current situation.

"The head of any good business operation always will have his thumb on the financial controls," says Anthony. "This is good business practice."

Anthony said physicians in the worst shape financially are those "who don't know where the revenue is coming from.

"Without that information, it's difficult to analyze the situation," he said.

"Those that are not concerned enough with finances until the end of the year, those who lack the interest, are the ones in greatest danger," he added.

Accounts receivable should be looked at every month.

A rule of thumb, he said, is that accounts receivable divided by the monthly gross operating revenues should not exceed 2.5. In other words, if you had accounts receivable worth $37,500 and monthly gross operating revenues of $12,000, you would come up with a figure of 2.5.

"If it went to 3, I'd start to get worried," he said. "If it went up to 3.5, I'd be very concerned."

He said physicians should look at receivables often to see if more and more people are paying late, or not paying at all.

"At six months, you have a 67 percent likelihood of collecting," Anthony said. "At 12 months, it drops to 43 percent."

The obvious inference is that the closer to service payment is made, the better. With the passage of time, patients have a way of forgetting just how important the medical aid was to them at the time it was sought.

Insurance

Physicians should understand third party payors.

"Insurance forms should be in the mail within 48 hours after the service was rendered," he said. "And forms should be mailed on a daily basis."

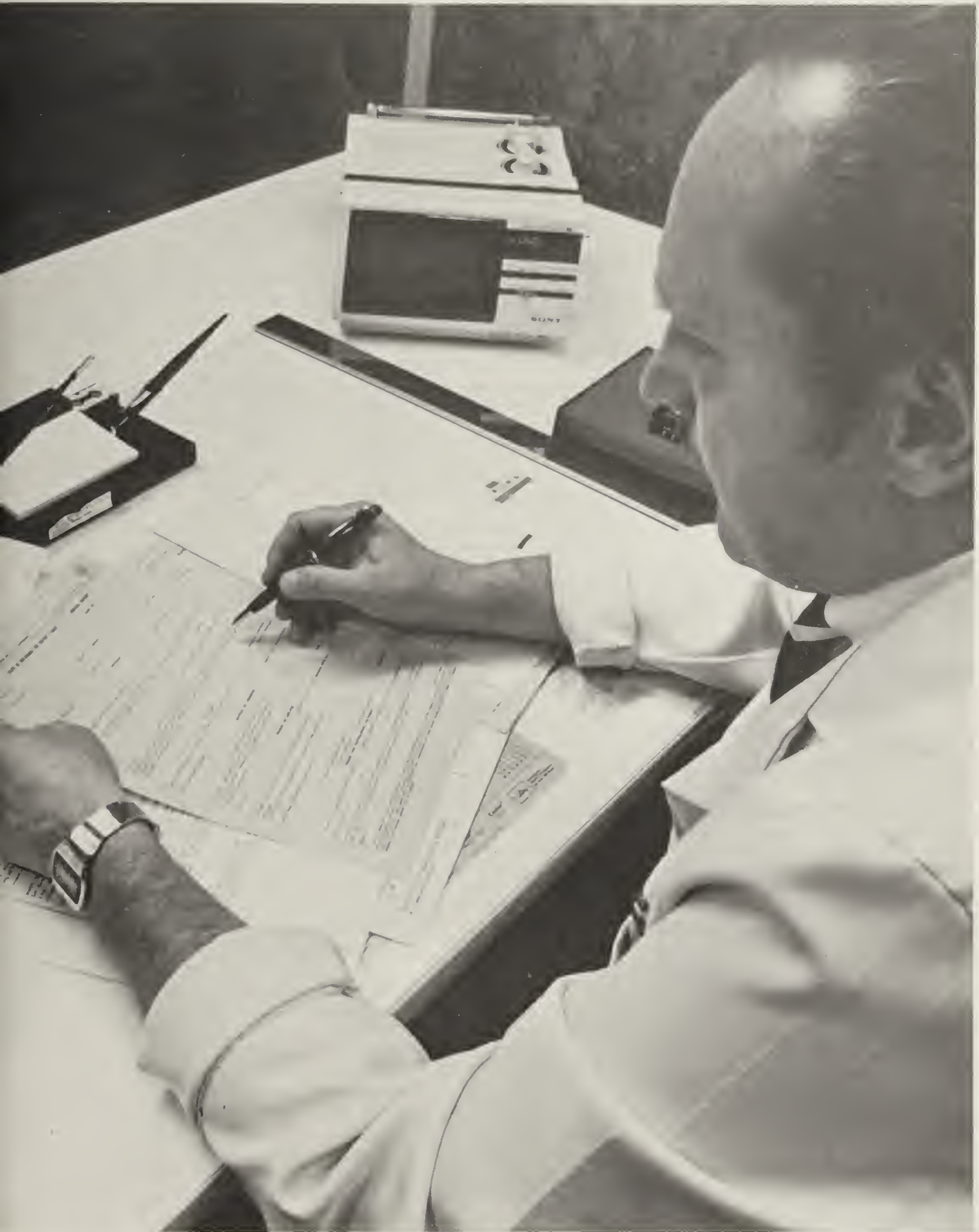
All the necessary information should be obtained at the initial contact with the patient to prevent wasted time.

The insurance claims should be kept in an accordian file and, if the physician has not heard anything within 55 days, a check should be made. He said Blue Cross/Blue Shield receives 80,000 claims a day.

"They can lose one," he said.

Continued on page 465

Ms. Eberly is a Lansing-area free-lance writer.



Physician Service Group endorses new office equipment leasing service

By John R. Schweitzer
Mason

MEDI-LEASE™ is a capital equipment leasing plan administered by Barnhill Philip Services, Inc., a Mason, Michigan-based company founded in 1980 by Merritt F. Barnhill and William L. Philip. BPS primarily is engaged in commercial equipment leasing. BPS has a state-wide network of sales and marketing resources that serves to originate most types of equipment lease transactions related to Michigan's industries. It is a member of the Michigan Bankers Association and the American Association of Equipment Lessors.

MEDI-LEASE™ has been designed to meet the special wants and needs of the medical profession for their financing of business equipment acquisitions. MEDI-LEASE™ is a plan designed exclusively for MSMS members, with convenience and simplicity guiding its development over the past six months.

One unique feature that greatly enhances the plan's convenience for the physician, is the pre-arranged lease line of credit that is extended to each physician who applies for a MEDI-LEASE™ Card and meets the credit requirements.

A $20,000 line will be reserved; and when a purchase is made, all the physician has to do is give the vendor his MEDI-LEASE™ Card number and the lease will be automatically initiated.

If several items are acquired over a period of time from different sources and the MEDI-LEASE™ card is used, there will still be only one payment to make and one place to send it. Capital equipment leases will not be limited to $20,000 under the MEDI-LEASE™ plan but if that line is exceeded, BPS may require additional documentation from the card holder prior to approval.

Another unique service that MEDI-LEASE™ is offering free of charge to the physician, is the major acquisition analysis. This computerized analysis will determine the lease-cost method of financing and will provide an answer to that sometimes puzzling question: should I pay cash, borrow from my bank, or lease the equipment? If the physician desires enhanced liquidity, MEDI-LEASE™ also provides a service for sale and lease-back of existing office equipment and furnishings.

There are many advantages to leasing; here are several: Some if not all of the following factors affect the productive potential of money and suggest that leasing may be the *most cost effective* method of financing acquisitions of equipment for business use.

1. The physician's capital keeps on working: Every dollar the physician can keep free for use as working capital is a dollar that he may be able to turn over profitably, many times a year.

2. Two sources of potential profit: Leasing can provide the physician with potential profit from the use of the equipment and potential profit from the more advantageous employment of capital.

3. Bank credit is not diminished: By using leasing as a supplementary source of long term equipment financing the physician's bank line of credit is kept available for operational and short term financing needs.

4. There can be important tax benefits: On most equipment, writing off the lease payments can result in a greater deduction over the base period of the lease than would normal depreciation.

5. Budget limitations can be overcome: In situations where limited budgets would ordinarily delay or prevent the acquisition of desirable equipment, leasing makes the equipment immediately available. Minimal cash outlay and small monthly payments can be arranged to fit the tightest budget schedules.

6. Less initial cash outlay: Upwards to 100 percent financing is available as compared to a maximum of between 70 and 90 percent offered by most banks or financing plans.

7. Full use of investment tax credits: Tax credits can be assigned to the lessee if it is desirable.

8. A profit dollar isn't used: Lease payments are made from before-tax earnings rather than from net or after-tax profits.

9. No loan fees or compensating balance requirements.

10. Lessees have the equipment they need for today and pay for it with tomorrow's dollars.

11. Fixed payments are a hedge against inflation.

Careful financial planning by physicians, when capital equipment acquisitions are contemplated, can result in increased retention of income that would normally be lost to taxation. If leasing is selected, not only are earnings usually increased but, because of the nature of money, the total cost of the acquisition usually is reduced to its lowest possible factor.

John R. (Jack) Schweitzer is director of marketing for Barnhill Philip Services Inc. (BPS) with 30 years of experience in Market Research and Product Development.

Here are other MSMS/PSG services

Physician
Service
Group, Inc.

There are many products and services on the market which can help the physician run a medical practice more smoothly and efficiently.

But how does the physician distinguish which are readily available, economical and of good quality?

That is where the MSMS Physician Service Group, Inc., comes in. The PSG's objective is to increase the economic well being of Michigan physicians, both in their business and personal life.

Another PSG objective is to aid the physician by making available tools and resources of reasonable cost and constant quality.

Here are some of the services provided:

(1) Practice management consultations (profiled in the major article of this section) and seminars. Seminars are offered to residents about to establish themselves in practice and for physicians who have been serving patients for years.

(2) Bill collecting services. The PSG endorses the I.C. Systems Collection Company for use by physicians in collecting indebted accounts. Since the PSG endorsed IC Systems in 1980, the company has collected over $6,000,000 for Michigan physicians. Currently, over 2,000 physicians take advantage of this program, at a cost substantially below other collection companies' charges.

(3) Credit card service. The MSMS/PSG Credit Card Program has 350 MSMS members enrolled, allowing patients to pay bills by credit card. PSG collects the payments and every two weeks sends the physician a check for the appropriate amount, less a small administrative charge. This system reduces physicians' costs in sending out statements and in office collection efforts.

(4) Administrative services. The PSG provides office staff for several Michigan physicians' and other health care professionals' organizations. This includes member records, arrangements of major meetings, staffing for committee and general membership meetings, and newsletter services.

The MSMS Physician Service Group considers many factors when offering new services or endorsing products and services for MSMS members. These include

(1) The overall contribution to the smooth and efficient running of a physician's practice.

(2) The ability of the service or product to meet a large number of the physician's needs.

(3) The availability of the services to physicians throughout the entire state.

(4) The organization's background in the field.

(5) Its experience in dealing with physicians in the past.

(6) The organization's record of quality and success.

It is worth an MSMS member's time to analyze and take advantage of the services offered them by the PSG.

CONSULTATION/*Continued*

"Make sure you're on top of it if it's yours."

On the matter of checking accounts, Anthony said physicians could pick up some extra money without doing one thing differently in their office routines.

"Just make sure you have automatic transfer into your savings account," he said.

There's no need to hang onto the money in a checking account when it could be earning interest in savings.

He suggested physicians stay with banks instead of going to other financial institutions since "banks can meet all your needs. They're by far the best place to be."

He said, of course, the checking account should be balanced monthly and comparisons made to previous months. Deposits should be made at least twice a week, if not daily.

Suggestions

In other areas of business operations, Anthony had some suggestions.

Telephones — Have a busy signal study done. Michigan Bell will do this for free and it could make the difference between lost business and a full appointment book. If the study shows that the phone rings busy 30-40 times, install another line. Special service is now available where a caller will be automatically switched to an open line if the main one is busy.

Salesmen — These tenacious people can be handled with a sensible system. Simply set a policy for seeing them, i.e. when, how long. Have this printed on cards and when they visit, simply have the receptionist give them a card. This not only gets them out of the waiting room, it lets them know you mean business.

Call backs — Set a specific time each day to handle phone calls with patients. Let them know when it is. Find out where they're going to be and tell them to stay off the phone during the call back time.

Appointment books — Design your own book to fit your practice. Monday is not going to look like Tuesday or Wednesday. Build your schedule so you get out on time.

When Anthony is through looking at a practice — a procedure taking from one to two days — he'll sit down with the physician and make recommendations. He'll compare revenues and expenses with similar physicians' practices. A system will be devised to anaylze finances and figures.

But, beyond that, it's up to the physician to carry through on the recommendations.

It's all a matter of getting down to business.

Don't punch out our lytes!

The article by my respected Task Force Chairman, R. Jack Chase, MD, in the May issue of *Michigan Medicine* (Vol. 82, pg 320) very properly points to the need for physicians to help control medical care costs. Some of my own suggestions on the subject appeared in these pages a few years ago.

Unfortunately, the dollar savings (Doctor Chase) projects in his article are unrealistically high as a result of the common fallacy of equating costs with charges. The published laboratory test charges (list prices) result from a complicated process which begins with an attempt to establish the basic economic cost per test. This usually involves average workload data and does not distinguish between the cost of doing the first 50 sets of electrolytes each day and the cost of the next 10, 20, or 50 sets. Obviously the fixed costs remain no matter how few tests are done, and conversely, the actual cost of additional tests declines at some point to a few cents for reagents.

Once the basic economic cost is established, it is massaged by a variety of cost-allocation factors, which pay for the non-revenue producing centers of the hospital, to produce the accounting cost per test. This is enhanced by factors such as bad debts, educational costs, equipment replacement, and community consensus pricing before the charge is finally published. By this time it usually bears little relation to the actual cost of doing an individual test. Furthermore, since most hospital income results from cost-reimbursement mechanisms, few patients are directly affected by the charges.

To return to the electrolyte example, a reduction from 100 to 50 tests per day would result in some reagent savings and some savings in technologist time, but no change in fixed costs. It would certainly not save $1,000 per day. It might save about $100 per day, if the technologist could be spared from the electrolyte instrument for four hours to do other tasks. Given the unpredictable need for electrolytes, this is not likely. Similarly the sodium and potassium determinations in his example are done on a dual channel analyzer. To order half of the 7,900 determinations as either sodium or potassium would indeed reduce the charges by $19,750. But the reduction in cost would be negligible.

The incentives for indentifying and controlling costs under the cost-reimbursement system are minimal; under DRG's they will be critical. My concern is that cost-effectiveness analyses be based on actual resource consumption (cost) and not on charges. Let us not compromise our standards of patient care for what may be insignificant cost savings.

John H. Libcke, MD
Director of Laboratories
Pontiac General Hospital
Pontiac

More on lytes

I read your article "Won't someone turn down the lytes?", and I had misgivings that you have confused the terms "costs" and "charges" with the result that your prospective savings are grossly overstated.

Firstly, I absolutely support your assertions that far too many electrolyte assays are ordered, and that they, like all other tests, should be carefully selected. However, the "cost savings" calculations are incorrect.

The figures $5 for each individual "lyte" and $20 for the four are charges, not costs. The vast majority (± 80 percent) of hosital patients have their expenses reimbursed by cost-paying third parties (e.g. Medicare, Blues). Only the 20 percent with commercial or no insurance pay charges. The cost to perform a lyte is about $2.25 - $2.50, including direct and indirect costs and allowances (unreimbursed costs). To do all four lytes doesn't cost any more than a few pennies (for reagents). Therefore, about 80 percent of patients pay (albeit indirectly) about $2.50 for any lyte (or lytes) determinations. Plugging this into your calculations:

December 1982: 2,300 electrolytes
.8 × 2,300 × $ 2.50 = $ 4,600
.2 × 2,300 × $20.00 = $ 9,200
$13,800,
not $46,000

If, as you say, 50 percent of those patients needed only potassium, you would save $15 for each of the 460 who don't have a charge payor, or 460 × $15 = $6,900, not $17,250. This, of course, assumes that the mix of patients who get lytes ordered is the same as the mix of all hospitalized patients. Actually, there are probably more lytes ordered on Medicare patients than on others which would further reduce the potential savings.

The same analysis would be applicable to your other examples of sodium and potassium, chloride, and CO_2 determinations. In short, the savings would be far less than you speculated.

Let me again restate that I applaud your efforts toward proper utilization of laboratory services; misutilization is a serious problem.

However, it is most important that doctors understand the reimbursement system, and particularly the difference between "cost" and "charge" when they attempt to weigh the financial benefits of this or that addition or deletion of a diagnostic or therapeutic procedure.

Sheldon F. Markel, MD
Head, Department of Pathology
St. Joseph Mercy Hospital
Ann Arbor

Doctor Chase replies: At the time I wrote the article, I was aware of the difference in the cost-charge relationship, but was unable to find reliable figures as to the percentage of patients that would apply more to the cost aspect than to the charge aspect. I am glad to have your clarifications on this situation, which we all agree needs improvement. I stand corrected, however, on the specifics.

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*Anusol Ointment contains PRAMOXINE HCl–a non-"caine," topical anesthetic derived from morpholine and generally recognized as safe and effective for external use. Pramoxine is as potent as benzocaine but appears to be less sensitizing. Its distinct structure tends to minimize the risk of cross-sensitivity. Pramoxine acts within three to five minutes, and its anesthetic effect can last as long as several hours. In addition, Anusol Ointment contains emollient, lubricant, wound-healing, and protectant ingredients.

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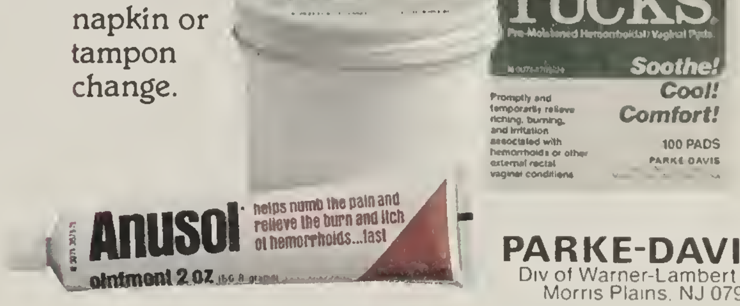
After episiotomy or other vaginal/rectal surgery, **Tucks** serve also as an ideal hygienic wipe or wet compress.

In nonpregnant women, Tucks are a useful vaginal wipe during menstruation or after napkin or tampon change.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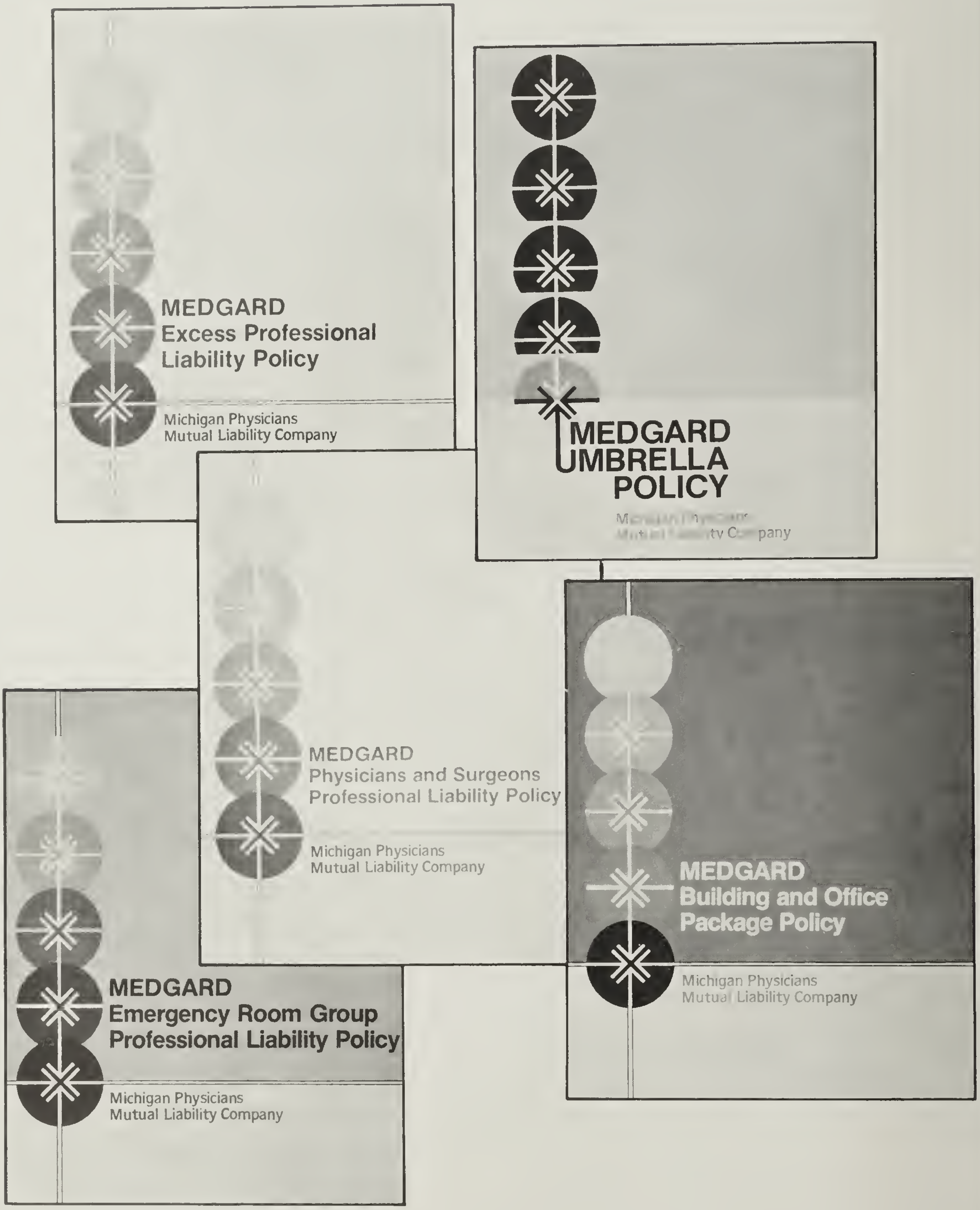

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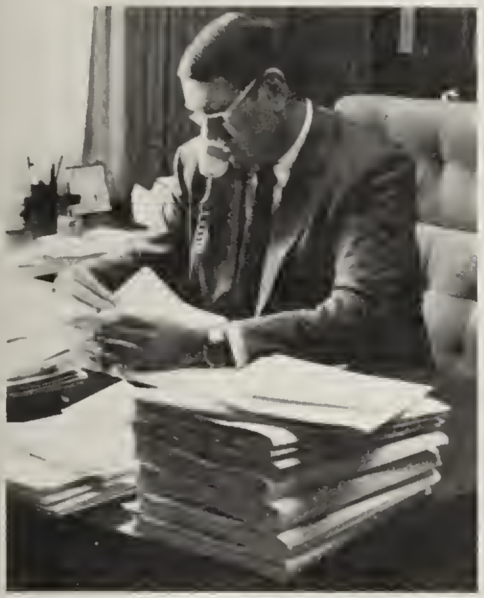
AND WHAT YOU GET.



Service. Claims service is what you buy a professional liability policy for in the first place. Our policies are backed by the most experienced professional liability claims staff in Michigan. Our claims representatives return your phone calls and keep you informed of the progress of any claim in which you may be involved. These professionals and the excellent defense attorneys assigned to represent our policyholders have helped Michigan Physicians build our excellent reputation for claims services.

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Claims
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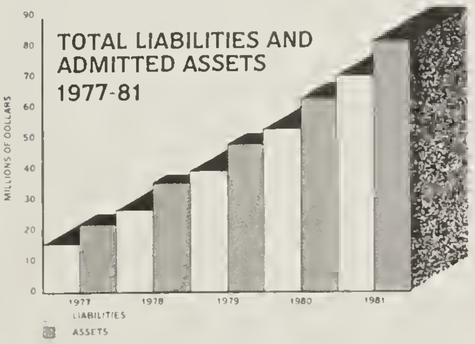
Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our inhouse computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

Stability. Assets of over $88 million back our policies. That's more than $20,000 for each physician insured with us for primary, professional liability. Total surplus of $11.4 million is further evidence of our financial strength and stability. In other words, our policyholders have $3 of equity for every $4 of net premium that we write annually.



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Alternative health care professionals: An MSMS position statement

The MSMS Task Force on Alternative Health Care Professionals is the originator of the following white paper which became official policy with its adoption by the MSMS Board of Directors (Council) on April 29.

The medical profession is dedicated to the preservation of quality health care for all people. The Michigan State Medical Society supports the definition of the practice of medicine as defined in Part 170 of the Public Health Code as follows:

" 'Practice of medicine' means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts."

Therefore, the Michigan State Medical Society views with great alarm the trend towards the medical diagnosis and treatment of human disease by those who are not licensed to practice medicine.

The Michigan State Medical Society further supports the current wording of Article 15 of the Public Health Code titled "Occupations." This section of the code defines scope of practice for 13 health professions and delineates the relationship of professions one to another.

MSMS supports Section 16265 of the Michigan Public Health Code which states:

"An individual licensed under this article to engage in the practice of chiropractic, dentistry, medicine, optometry, osteopathic medicine and surgery, podiatric medicine and surgery, psychology, or veterinary medicine shall not use the terms 'doctor' or 'dr.' in any written or printed matter or display without adding thereto 'of chiropractic,' 'of dentistry,' 'of medicine,' 'of optometry,' 'of osteopathic medicine and surgery,' 'of psychology,' 'of veterinary medicine' or a similar term, respectively."

Chiropractic

Section 333.16401 of the Public Health Code defines the practice of chiropractic as "that discipline within the healing arts which deals with the nervous system and its relationship to the spinal column and its interrelationship with other body systems. Practice of chiropractic includes:

"(i) Diagnosis, including spinal analysis, to determine the existence of spinal subluxations or misalignments that produce nerve interference, indicating the necessity for chiropractic care.

"(ii) The adjustment of spinal subluxations or misalignments and related bones and tissues for the establishment of neural integrity utilizing the inherent recuperative powers of the body for restoration and maintenance of health.

"(iii) The use of analytical instruments, nutritional advice, rehabilitative exercise and adjustment apparatus regulated by rules promulgated by the board pursuant to section 16423, and the use of x-ray machines in the examination of patients for the purpose of locating spinal subluxations or misaligned vertebrae of the human spine. The practice of chiropractic does not include the performance of incisive surgical procedures, the performance of an invasive procedure requiring instrumentation, or the dispensing or prescribing of drugs or medicine."

Section 16423 referred to in paragraph (iii) above indicates that the Michigan Board of Chiropractic "shall promulgate rules to establish criteria for the approval of analytical instruments and adjustment apparatus to be used for the purpose of examining patients . . . "

The Michigan State Medical Society policy on chiropractic adopted in 1982 states that "MSMS reaffirms that a physician should at all times practice a method of healing founded on a scientific basis. A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other provider of health care services permitted by law to furnish such services whenever the physician believes that this will benefit the patient. As in the case of referrals to physician specialists, referrals to limited practitioners should be based on their individual competence and ability to perform services needed by the patient."

MSMS reiterates its position against the use of testimonials in advertising as such claims tend to mislead the public.

Nursing

The proposed rules for nursing currently are under review. The rules are being promulgated by the Board of Nursing and relate directly to specifics for specialty certification of nurses. Administrative rules have the force and effect of law and therefore these draft rules have immense importance to medical care patients in Michigan.

The Task Force identified several areas of concern regarding the proposed rules for nurse specialty certification.

1. Scope of Practice for nurse anesthetists, nurse midwives and nurse practitioners.

The "Practice of Medicine" is defined in Section 333.17001(1)(c) as: "the diagnosis, treatment, prevention, cure or relieving of a human disease,

Continued on page 472

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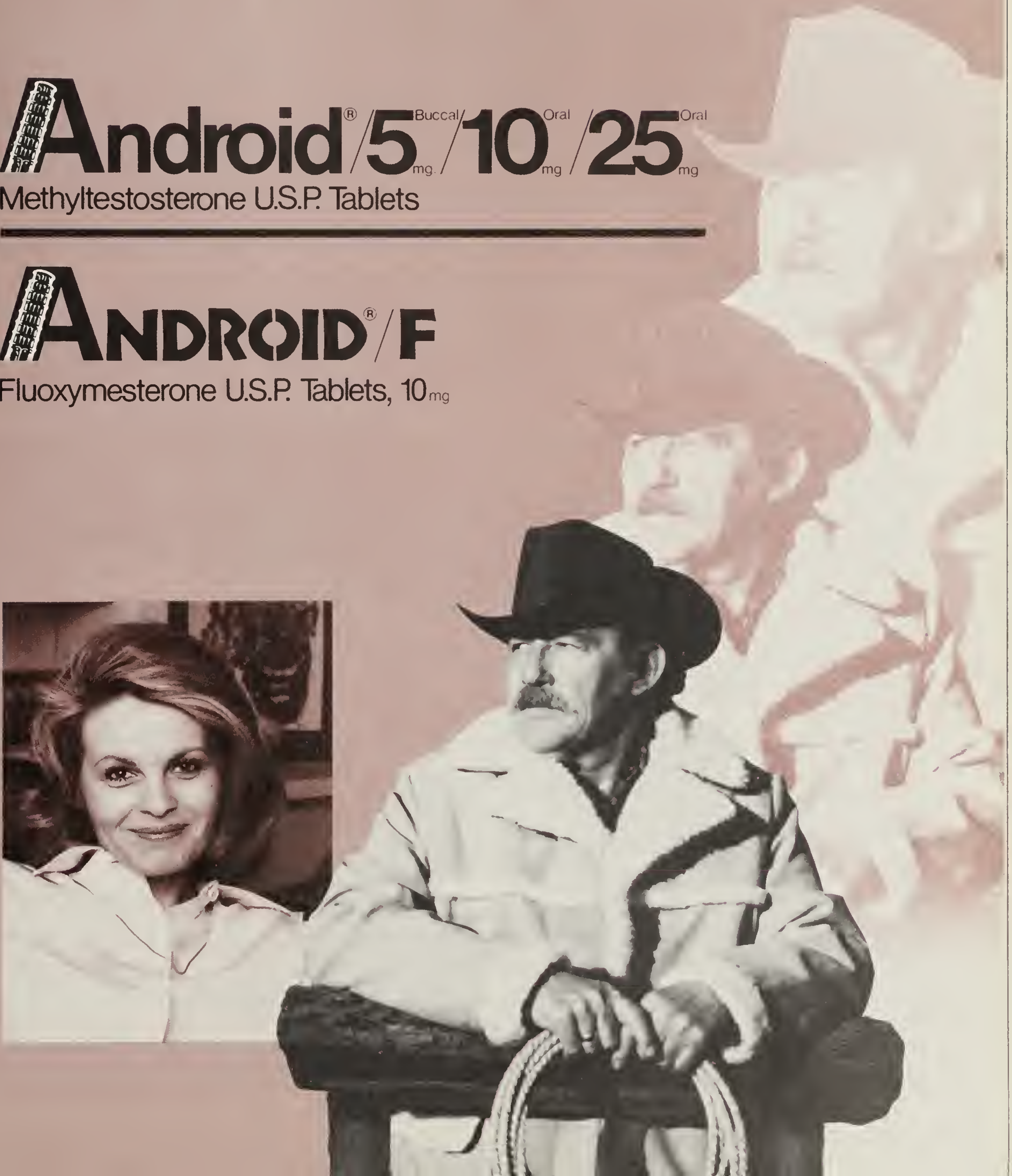

ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do any of these acts."

The "Practice of Nursing" is defined in Section 333.17201(1)(a) as: "the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury or disability."

The Task Force is concerned that the language in the proposed rules includes or seems to include medical judgement by use of the words "assessment, evaluation and interpretation." These medical judgements appear to be outside the scope of practice of nursing regardless of qualifications.

2. Delegation of physician responsibilities to nurses.

Section 333.16101 of the Public Health Code stipulates: " 'Delegation' means an authorization granted by a licensee to a licensed or unlicensed individual to perform selected acts, tasks, or functions which fall within the scope of practice of the delegator and which are not within the scope of practice of the delegatee and which, in the absence of the authorization, would constitute illegal practice of a licensed profession."

The nurse specialist, working with a physician, may have certain responsibilities for making medical judgements delegated to him or her. However, the direct relationship to the physician should be included in the rules so as not to subvert the delegation section of the Public Health Code or the public perception of the physician-patient relationship. A direct relationship with physicians is not included in all sections of the nurse specialty rules.

Additional questions must be raised regarding malpractice insurance for nurse specialists and certification of continued competency. The Task Force also raises the following issues:

A. Will the nurse practitioner eventually request hospital privileges?

B. Will the nurse practitioner be allowed to do office surgery?

C. How will the government protect the public from nurse practitioner malpractice?

3. "Grandfathering in" of nurse practitioners.

A section of the proposed rules indicates that nurse practitioners applying for certification within five years of the effective date of the rules will not be required to have either a bachelor of science degree in nursing or a formal advanced program in a specialty area of nursing.

The Task Force recognizes that there could be many advantages to grandfathering. However, in the written testimony made to the Board of Nursing we note:

" . . . in this instance, the quality of care for citizens of Michigan transcends the good intentions of the grandfathering clause."

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The Task Force believes that physicians and other health professionals should be part of a multi-disciplinary team approach to the delivery of quality health care. Therefore, there should be a clear delineation between the practice of nursing and the practice of medicine.

The concerns of the Task Force regarding the proposed rules for nurse specialty certification were communicated to the Board of Nursing in a letter from Thomas R. Berglund, MD, Chairman of The Council of MSMS, on July 6, 1982. MSMS hopes that the Board of Nursing will redraft the proposed rules and, in so doing, will modify the rules in a manner which addresses the concerns of MSMS. Once the rules are accepted by the Board of Nursing in final form, they continue through the rules process which includes action by the Joint Administrative Rules Committee of the legislature. MSMS will continue to monitor and be active in the rules process.

Pharmacy

Section 333.17707(5) defines the practice of pharmacy as:

"a health service, the clinical application of which includes the encouragement of safety and efficacy in the prescribing, dispensing, administering, and use of drugs and related articles for the prevention of illness, and the maintenance and management of health. Professional functions associated with the practice of pharmacy include:

(a) The interpretation and evaluation of the prescription.

(b) Drug product selection.

(c) The compounding, dispensing, safe storage, and distribution of drugs and devices.

(d) The maintenance of legally required records.

(e) Advising the prescriber and the patient as required as to contents, therapeutic action, utilization, and possible adverse reactions or interactions of drugs.

The Task Force reiterates that pharmacists are not prescribers and, in that context, should not be able to substitute one drug for another without physician authorization. Substitute, as defined in the Public Health Code means "to dispense, without the prescriber's authorization, a different drug in place of the drug prescribed." This does not affect generic substitution. A pharmacist who would become a prescriber would be effectively acting outside the designated scope of practice. There is a growing movement among professional pharmacists that an independent pharmacy practice is the wave of the future and would best serve the needs of both the consumer and the physician. The Task Force feels that the pharmacist is one member of the multi-disciplinary health care team and, as such, the pharmacist should continue to perform tasks appropriate to the parameters set forth in the Public Health Code.

Physical Therapy

Section 333.17801(1)(b) defines the practice of physical therapy as:

"The evaluation or treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting,

Continued on page 474

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or alleviating a physical or mental disability upon the prescription of an individual holding other than a subfield license issued under parts 166, 170, 175, or 180. It includes treatment planning, performance of tests and measurements, interpretation of referrals from physicians, instruction, consultative services, and supervision of personnel. Physical measures include massage, mobilization, heat, cold, air, light, water, electricity, and sound."

(NOTE): Prescriptions may be issued by dentists (166), allopathic physicians (170), osteopathic physicians (175), and podiatrists (180).

The Task Force recommends continued support of this section of the Public Health Code and Section 333.17831 states that the license of a physical therapist may be revoked for practicing physical therapy without a prescription from an MD, DO, dentist or podiatrist.

Physician's Assistant

The rules and regulations governing physician's assistants which appear in the Public Health Code are extensive and specific. The Task Force concurs with the current stipulations in the code as written.

Podiatry

Section 333.18001(1)(b) defines the "practice of podiatric medicine and surgery" as:

"the examination, diagnosis, and treatment of abnormal nails, superficial excrescenses occurring on the human hands and feet, including corns, warts, callosities, and bunions, and arch troubles or the treatment medically, surgically, mechanically or by physiotherapy of ailments of human feet or ankles as they affect the condition of the feet. It does not include amputation of human feet, or the use or administration of anesthetics other than local."

The Task Force feels that the intent of the Public Health Code is to limit podiatrists to performing those procedures which can be performed under local anesthesia. This raises the concern that podiatrists are beginning to get hospital privileges to perform procedures under general anesthesia. In general, podiatrists who have patients admitted will have someone else administer the anesthesia. However, procedures which would require the use of general anesthesia are likely to be more extensive and require more extensive training. Such surgery involves greater risk. These more extensive procedures should be limited to those physicians qualified to perform them.

Therefore, the Task Force recommends that the definition of the practice of podiatric medicine and surgery be legislatively amended to read:

"the examination, diagnosis, and treatment medically, surgically, or mechanically of abnormal nails, superficial excresenses occuring on the human feet, including corns, warts, callosities, and bunions, and arch troubles. It does not include amputation of human feet, or the use of administration of anesthetics other than local."

The above definition omits physiotherapy because it was felt that physiotherapy would only be appropriate when the ankle joint is involved. The foot, by definition, is that portion of human anatomy distal to the tibiotalar articulation.

Psychology

Section 18201(1)(b) defines the practice of psychology as:

"the rendering to individuals, groups, organizations, or the public of services involving the application of principles, methods, and procedures of understanding, predicting, and influencing behavior for the purposes of the diagnosis, assessment related to diagnosis, prevention, amelioration, or treatment of mental or emotional disorders, disabilities or behavioral adjustment problems by means of psychotherapy, counseling, behavior modification, hypnosis, biofeedback techniques, psychological tests, or other verbal or behavioral means. The practice of psychology shall not include the practice of medicine such as prescribing drugs, performing surgery, or administering electro-convulsive therapy.

The Task Force consulted with the Michigan Psychiatric Society regarding the position of the Society on the relationship of psychiatry and psychology. The major concern is that psychologists sometimes extend beyond their training into differential diagnosis. Psychologists have definite strong points. They have excellent testing skills and some, if they have good psychotherapeutic training, are excellent in patient treatment.

Another concern is related to supervision of psychologists. There is always the possibility that patients may have presenting symptoms which have organically based psychopathology. The true diagnosis may or may not be recognized by a psychologist.

A third concern relates to the prescription of therapeutic drugs for organic disorders which require that kind of treatment. Sometimes, psychologists find physicians who will prescribe drugs at the psychologist's request. MPS notes that the physician who prescribes without seeing a patient will not know enough about that patient to be able to determine whether such prescriptions are appropriate.

Fourth, a future concern is that psychologists will be seeking hospital privileges. The psychiatric society stands firmly against hospital privileges for psychologists because of their lack of skill and training in differential diagnosis.

The Michigan Psychiatric Society has proposed a certification procedure for out-patient psychiatric clinics. A multi-disciplinary auditing team would review the diagnoses of various cases. The team would have psychiatric input and, according to the MPA, will assure the best possible treatment for clinic patients.

MSMS recognizes the differences between the two professions, psychiatry and psychology. A psychiatrist is a physician particularly skilled in differential diagnosis. Psychologists are prohibited from prescribing drugs.

MSMS concurs with the Michigan Psychiatric Society in its position that any client of a psychologist who is taking drugs must be under the immediate supervision of the prescribing physician.

A separate point of discussion revolved around the continued requests for certification by sub-specialties in psychology. The Task Force opposes further dilution of the practice of psychology and recommends that the term psychologist be limited to those who have met the current educational requirements and are licensed to practice psychology.

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Update on PROM

By Deborah Zannoth
East Lansing

MSMS is working to organize physicians' peer review on a statewide basis as it becomes increasingly apparent that the Reagan Administration is not supportive of current PSRO efforts.

This is to ensure that Michigan MDs do not lose their traditional rights to pass review on their colleagues' delivery of care, or worse, that this function might be placed in the hands of non-physicians.

MSMS has steadily advanced along its timetable to establish the Physicians Review Organization of Michigan, a new body initiated by the MSMS Board of Directors (Council) in December, 1981.

The following article brings MSMS members up to date on PROM's development.

The 1982 MSMS House of Delegates gave the go-ahead for MSMS to establish a statewide organization to promote, market, monitor and provide a state level appellate mechanism for peer review. By the 1983 House of Delegates, PROM had been incorporated. The House not only endorsed the activities of PROM but also allocated an additional $12,000 in funds to bring PROM to operation.

PROM was incorporated on Jan. 19 as a non-profit company and wholly-owned MSMS stock subsidiary. The organization's general business will be to provide for peer review services by contract with its customers. Utilization review data will be submitted to PROM and then provided to regional or local peer review organizations which will complete the actual review.

MSMS anticipates the regional organizations established during the federal PSRO program will function as the subcontractors for PROM.

The 1983 House of Delegates also instructed PROM to work with the Michigan Association of Osteopathic Physicians and Surgeons, Inc. and encourage their support and participation in PROM. After several meetings and negotiations, MAOPS agreed to nominate four members to the PROM Board. MAOPS will also be allowed shares of stock in the corporation.

PROM established as its marketing audience private insurance companies, BCBSM and private employers. To date, PROM is holding discussions with officials of BCBSM and is in the final negotiations of a contract with the Michigan Education Special Services Association (MESSA).

PROM also has received inquiries from other Michigan third party carriers who are responding to their policy holders' requests for private review.

PROM has met with the current PSRO directors and formed a Technical Work Group to discern the capabilities of each PSRO and the different types of review that each PSRO provides. The Board also has been working with MEDRO, the review organization for the Wayne County area, in order to develop the necessary review resources for PROM in Wayne County. (The Wayne County Region has been without a PSRO due to defunding.)

The PROM board intends to bid for the PRO (peer review organization) contract when the government provides the future funds for these organizations. The PRO will be responsible to review all Medicare services in each state and will be designated by the Health Care Financing Administration.

This contract also will cover the PRO review of inpatient Medicare services required by the federal government when it enacts the diagnostic related group (DRG) reimbursement system in October.

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

The PROM organization

The 24 PROM board of directors members are elected by the MSMS Board and serve staggered three-year terms. Twenty members are either allopathic physicians or osteopathic physicians. Ten of these physicians are nominated by a regional peer review organization. Six are nominated by MSMS and four will be named by the Michigan Association of Osteopathic Physicians and Surgeons. Also serving on the PROM Board are two non-physician public members and two representatives of the Michigan Hospital Association.

The Board consists of the following individuals:

Charles W. Aldridge, MD
Mary O. Anderson, MD
Dale E. Baker, MD
John E. Bryan, MD
Aleck Capsalis
William S. Carpenter, MD
LeRoy Fahle
Daniel R. Guyot, MD
Jay K. Harness, MD
Clare Keller, PhD
Gail Klegon
Robert C. Packer, MD
Robert C. Prophater, MD
Douglas D. Sherk, MD
Donald Smith, MD
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Charles A. Thompson, MD
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Donald W. Visscher, MD
William Weston, MD
Gordon W. Willoughby, MD
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Ad Hoc Advisory Committee

Donald K. Crandall, MD
Robert H. Hamburg, MD
James J. Humes, MD
Gerald H. Mandell, MD
Warren Tryloff

Officers of the Board elected at its first organizational meeting are as follows:

President — Frederick W. VanDuyne, MD
Vice-President — Mary O. Anderson, MD
Secretary — LeRoy Fahle
Treasurer — Robert C. Prophater, MD

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MSMS focuses on patient with Annual Scientific Meeting

By Charles R. Downs
East Lansing

Doctor Rovner

Q. When is chairing a committee like teaching?

A. When it is the Planning Committee for the MSMS Annual Scientific Meeting (Nov. 15-17 in Dearborn) and the chair is David R. Rovner, M.D.

"Being program chairman is an extension of what I do day in and day out," says the professor of medicine at the Michigan State University College of Human Medicine.

"I teach practicing physicians and medical students and I am especially interested in continuing medical education. The meeting is just another way of getting to a larger number of practicing physicians."

To someone who does not know Doctor Rovner, those words might portend a rather dry meeting — a lot of academic subjects taught by academicians and not often relevant to practicing physicians. But that kind of meeting belongs to the past, says Doctor Rovner.

Not bashful

"We have paid a lot of attention to feedback from physicians and I have seen a shift in the character of the meeting during my years on the committee. It is now based heavily on practical matters which practicing physicians will find of interest and will be of importance in the day-to-day management of their patients.

"We are not terribly bashful about telling section chairs what has worked well in the past and what has not worked very well, or, indeed, what we would like to hear about."

As an example, Doctor Rovner notes that the committee has had requests from some specialties to present information about high technology with the focus on the equipment involved.

"We are very careful to change the focus to what could and should be done for the *patient* with the high technology," says Doctor Rovner. "We also push for information on the cost-benefit ratio — not only how it can be used but when it should be used.

"It is very easy to overuse high technology. Much of the increase in the cost of health care has been due to the availability of high technology."

All of that may sound like heresy on the part of a professor who calls himself "a super subspecialist as far as my research is concerned."

But Doctor Rovner doesn't find it inconsistent. His research has dealt with control of aldosterone biosynthesis. But he sees himself not as a specialist but as a generalist with a very specialized interest.

People contact

Interest in general medicine and general education is part of the reason he came to MSU 12 years ago, Doctor Rovner points out.

"This is a community-based medical school. We believe interaction with community physicians is important, necessary and right." In that way, too, being on the Annual Scientific Meeting Planning Committee is just an extension of those principles."

Doctor Rovner at one time was an undergraduate chemistry major at Temple University and had thoughts of going on for a PhD in that subject to do research. But he opted for medical school because he wanted the people contact.

After receiving his MD degree and an Achievement in Research Medal at Temple in 1955, he did his postgraduate work in San Francisco, San Antonio and Ann Arbor, ending up as a member of the faculty of the Division of Endocrinology and Metabolism at University Hospital in Ann Arbor.

At the University of Michigan, he found the kind of work he had sought — half-time research and half-time clinical faculty, enabling him to satisfy his wish to do research and his wish to have people contact. But in the early 70s, he began thinking more about his teaching.

"I love to teach and felt my teaching abilities were being underused. So I looked around and found this place (MSU) and a body of people whose views matched my own.

Doctor Rovner has continued his interest in research but the focus has changed. He now collaborates with colleague Arthur S. Elstein (Ph.D.) on studies of how physicians make clinical decisions.

DRG course

One result of that research will be a course taught by Doctor Rovner on "Diagnostic Related Groups" at the Annual Scientific Meeting. The course, sponsored by the Program Committee, will be looking at the new federal plan to pay for Medicare hospitalization on a flat-rate basis for certain diagnostic categories.

Although Doctor Rovner has serious questions about the overall result of the federal plan, he points out that physicians should do what is optimum for the patient under any kind of financial plan.

"Our view is going to be that there are some techniques for making the best — or the optimum — clinical decision. And, if one does that with individual patients, one is likely to spend no more or no less than the optimum amount of money for that patient.

"We are not looking at costs or at benefits but at the relationship between the two. You can define that as efficiency."

Charles Downs is a Lansing-area freelance writer.

CME OPPORTUNITY

> "A fundamental need of most people who experience a chronic condition is the need to know."
> Richard Hamilton, M.D.
> *The Herpes Book*

Herpes — what you should know

By Stanley Alfred, MD
Flint

With this issue of *Michigan Medicine,* the MSMS CME Programming Committee introduces a new feature. This special section contains an educational article of general interest to physicians, followed by a quiz which can be filled out and returned to MSMS headquarters. Physicians who correctly answer at least 80 percent of the questions will earn one hour of Category I CME credit, for the minimum charge of $3 for MSMS costs. The quiz will be evaluated and returned to you with appropriate comments. In addition, there is space allowed for you to comment and to ask further questions.

Herpes simplex has become the most talked about medical subject in years. Rarely does a day go by where there is not some mention of herpes in the printed media, on TV or at a social gathering. What is this disease, and why has it catapulted from relative obscurity to its present position?

It is estimated that 20 million Americans are now suffering from genital herpes. Five hundred thousand cases will be reported this year. It is also estimated that 75 percent of Americans may have had labial or oral herpes (cold sores, fever blisters) at some time in their lives. The increase in genital herpes can be traced to the sexual revolution of the 1960s. Increases in the use of the pill, oral sex, the number of sex partners, and decreases in the use of barrier contraceptives (condoms, diaphragms, spermicidal foams), all are contributing factors.

Doctor Alfred is a dermatologist. His articles first were published in the *Flint Journal,* then in the *Bulletin of the Genesee County Medical Society*. Because they were written with the public in mind, Doctor Alfred suggests Michigan physicians might wish to reproduce these pages and make copies available to patients. They have his permission.

Herpes simplex is a spectrum of infections caused by Herpes Simplex Virus (HSV). The virus is classified into two groups, type-1 (HSV-1), and type-2 (HSV-2). HSV-1 is most commonly identified as the cause of cold sores on the lips, HSV-2 is most frequently linked to genital herpes lesions. These two types cause water blisters and lesions which cannot be readily differentiated. They manifest themselves in similar sores which are not confined to one area. That is, cold sores of HSV-1 origin may be spread to the genitals and other areas by hand or mouth and conversely HSV-2 may be spread to the mouth or other areas. In two University Health Center studies, it was found that about one-third of genital herpes infections were caused by HSV-1 while two-thirds were of the HSV-2 origin.

The virus needs to gain access to a living cell in order to replicate and survive. It is passed by an infected individual to another human by touching. It then enters a skin cell, takes over control, and reprograms the cell to manufacture more virus. One skin cell can product 100,000 viruses. The virus then migrates to two groups of nerve cells, the trigeminal ganglion which lies under the brain, and the sacral ganglion which is positioned near the spinal cord in the lower back. Here the virus resides in a dormant state. This fact is highly significant. While some individuals are fortunate enough never to have a reoccurrence, others are plagued throughout life. It is thought that recurrent infections happen when the virus migrates back down the nerve to the area of the skin near where the primary infection occurred. This event may be controlled by the body's immunity — its ability to defend against infection. It may also be influenced by certain triggers (stress, fever, sunlight, and menstruation).

The role of the virus has been described, but what about the signs and symptoms of herpes? Tingling, burning, or pain may occur two to 20 days before the appearance of a group of small blisters on a reddened area of skin. Enlarged and tender lymph nodes, fever and a downright sick feeling may all be part of a primary herpes infection. Usually, within three weeks the lesions heal and the affected individual returns to good health.

The lips, mouth, face and genitals are the most common sites of infection, but the virus can infect any area of the skin and other organs (eye, estimated 300,000 cases a year resulting in 15,000 cases of blindness each year; very rarely the brain and meninges — the membranes covering the brain and spinal cord).

After the primary infection heals, most people have little problem the rest of their life. But about one-third of patients will experience a recurrent herpes infection which usually occurs at or near the original site, is milder and heals more quickly (one week).

Special problems

There are some special problems concerning herpes that are important to know about — people should become aware of how herpes relates to the following: uterine cervical cancer, newborn infants, eye infections, encephalitis (brain infections), the immuno-suppressed patient, and the asymptomatic carrier.

Increasing evidence, including a four times greater incidence of carcinoma of the uterine cervix in women with genital herpes, points to the fact that the herpes virus may play a role in this cancer. Carcinoma of the uterine cervix is a common malignant disease. In the United States, 35,000 new cases and 10,000 deaths occur each year. It is a highly curable cancer if caught early. Because of the increased risk of this cancer in women with genital herpes, it is recommended that these women have a pap smear twice a year.

If the present epidemic of genital herpes continues, in the next 10 years there will be an enormous amount of pregnant women afflicted with the disease. This is important because herpes infection in a newborn infant is a catastrophic event. Sixty percent of babies born to mothers with active genital herpes (i.e. herpes at time of delivery) will contract Neonatal Herpes Simplex (herpes of the newborn). Of those babies affected, 60 percent will die, 20 percent will survive with serious damage to the brain or eyes. Only 20 percent will survive with no known impairment.

Because of these frightening statistics, pregnant women with either a history of genital herpes, or herpes below the waist and those having a sex partner with herpes should be followed carefully by their doctor. Cultures of the cervix and vagina must be taken regularly during the last part of the pregnancy. If the virus is present at or near delivery a caesarean section is recommended. Ideally this operation is carried out before rupture of the membranes and if it is, the newborn can be protected.

The most frequent cause of infectious blindness in the U.S. is herpes. Three hundred thousand people every year are affected with herpes keratitis (herpes of the cornea) and 15,000 of these lose their sight each year. Herpes keratitis can be treated with two relatively new antiviral agents (Stoxil and Vira-A). In order for these drugs to be effective, they must be started early in the course of the eye infection.

Herpes encephalitis (brain infection) afflicts up to 4,000 people each year in this country. It occurs when the virus migrates backward up to the brain instead of taking its usual course forward from the trigeminal ganglion to the skin. Over 70 percent of those with herpes encephalitis die. Most of the survivors will have permanent brain damage. An anti-viral agent, adenine arabinoside (ara-A), when given intravenously and early can reduce mortality in these patients from 70 percent to zero. In addition, over 75 percent of the survivors will have no or minimal brain damage.

Our immune system protects us against disease and allows us to recognize our own cells from foreign cells. When this system is compromised people are at greater risk, not only of contracting herpes but of the disease running rampant through their bodies and killing them. The most susceptible include transplant patients and those on chemotherapeutic drugs for treatment of cancers and other illnesses.

The problem of the asymptomatic carrier of herpes can't be overlooked. The scientific data is conflicting here, but in one study 46 percent of women shown to have genital herpes, by laboratory analysis, were without symptoms. In men asymptomatic genital herpes infections, mostly of the urethra, may occur less than one percent of the time. If the lesions of a recurrent herpes infection occur on the uterine cervix or if the numbers are small and the lesions are inconspicuous, the individual may not have any symptoms and not know they are infectious.

I have discussed some very serious problems that can occur in some herpes patients. In order to put things in proper perspective it should be emphasized that the number of people affected by these problems may be relatively small compared to the total number of individuals who have had herpes. These special areas are pointed out in order to increase public awareness of herpes potential for harm. If people are knowledgeable about the risks, steps can be taken to greatly reduce the possibility of some of these things happening.

Minimizing the spread

Can individuals avoid getting herpes? If they have it, how can they avoid spreading it to loved ones, or to other areas on their own bodies? And finally, how can this, so far, incurable disease be treated?

Many of the preventative measures are simple and are dictated by common sense. If followed, they do not give 100 percent protection but they will greatly reduce the risk of getting or spreading herpes. For many, the following recommendations may not be appealing, but the alternatives (abstaining from sex, anxiety and spreading or contracting herpes) are worse. You may call these measures the ten commandments for minimizing the spread of herpes:

1. Kissing anyone is to be avoided from the onset of the prodrome (when tingling, burning, itching, etc. are first noticed) till the lesions have healed and the scabs have disappeared. There is evidence that the virus may be in the skin during this entire time.

2. Washing the hands is essential when first arising in the morning. Many times, we inadvertently touch a cold sore during sleep and after awakening, the virus may be spread by rubbing our eyes. As has been pointed out earlier, 300,000 cases of herpes keratitis (infection of the cornea of the eye) and 15,000 cases of blindness occur in this country each year.

3. It follows that, during waking hours, after touching a cold sore or other herpes lesion, the hands should be washed immediately.

4. One study showed that herpes virus could survive on toilet seats for four hours. If anyone contracts herpes in this way, it would represent a minimal amount of cases, but it may be a good idea to wipe and line public toilet seats with paper before use.

5. Use your own towel if you have herpes lesions.

6. Avoid drinking from the same glass as someone with an active cold sore.

7. Abstain from sex when genital lesions are present. It must also be remembered that cold sores around the mouth can be spread to the genitals and to other parts of a partner.

8. Females with a history of recurrent genital herpes, but who have no apparent lesions or symptoms, should use a spermicidal foam when having intercourse. Their male partner is advised to use a condom. Spermicidal foams show some viricidal activity in the test tube and may help. Condoms offer some barrier to the virus.

9. Males with a history of recurrent genital herpes but with no apparent lesions should use a condom. Their partner may also want to use a spermicidal foam. The last two measures will tend to counteract the problem of the asymptomatic carrier (the individual with no apparent lesions who may be infectious). But, again, these measures cannot give 100 percent reassurance.

10. A positive mental attitude is very important in trying to combat this disease. There is evidence that the body's natural resistance to disease may be enhanced by a positive mental approach. There is also evidence that it may be decreased by negative attitudes. Indeed, reoccurrences seem to be less frequent and less severe in those who have a handle on this disease. Others, who run scared and are anxious, tend to have more frequent and more severe bouts.

For those who have herpes, treatment can be divided into symptomatic and therapeutic measures. For reducing the symptoms, the following is recommended:

1. Tylenol or aspirin for relief of fever and pain (usually in the primary herpes infection).

2. Avoid applying ointments and creams to the lesions. These may actually increase the time needed for healing.

3. Application of wet compresses, that promote drying of blisters, may be helpful. Burow's solution or Bluboro solution are best and can be obtained over-the-counter.

4. Calamine lotion, applied after the compresses, also promotes drying.

Therapeutically, many would-be "cures" have been tried in the past. These, for the most part, have not stood the test of either time or well controlled scientific study. They include a tuberculosis vacine (BGG), influenza vaccine, herpes vaccines, vitamin C, zinc, dietary increases in the amino acid lysine and decreases in arginine (another amino acid). Topically, applied ether, ice cube application, dye-light treatments, and finally the food additive butylated hydroxytoluene (BHT) have all had their unsuccessful therapeutic "place-in-the-sun."

What is the therapeutic hope for the future? That future is already here in certain areas of herpes treatment. Idoxuridine (IDU) and adenine arabinoside (Ara A, Vira A) are two antiviral agents that are effective in eye infections (herpes keratitis) if treatment is started early. In addition Ara A is useful in herpes encephalitis (brain infection). Again, treatment must be instituted early, before the coma stage of the disease. Acyclovir (ACU) is an antiviral that is now available in a cream for topical use. It is supposed to have some value in shortening the healing time of primary genital herpes. In immuno-suppressed patients with herpes it may also speed healing. Other antiviral agents, 2-deoxyglucose (DG) and phosphonacetic acid (PAA) have shown some favorable results in testing but are still in the investigational stage. Interferon (a substance produced by the body's own white blood cells) protects against viral infection. This and poly IC:LC, an interferon inducer, are other chemicals that may give herpes sufferers hope for the future.

Throughout the world, dedicated researchers are spending their lives trying to find a cure, and within the very near future, they will have it. When they do, the harvest will probably be better than anticipated because the doors will be unlocked, and we will have cures for other viral infections and, perhaps, cures for many cancers. (Some cancers are already known to be caused by certain viruses.) If, after all, we are able to stop a herpes virus from altering our genes and thus producing a cell gone awry, then it may be a short research-hop to stopping cancer-causing viruses from altering our genes. Who knows — the pernicious cold sore may shed some light at the end of the tunnel on cures for viruses and cancers.

Turn the page to take herpes quiz and earn Category I CME credit.

CME Quiz

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for one hour Category I Credit for the AMA Physician's Recognition Award and toward the relicensure requirements of the Michigan Board of Medicine, provided it is completed as designated.

To obtain one hour of Category I continuing medical education credit, please answer the following questions by circling the correct answer below. Complete and clip this entire page and mail it to: Sherry L. Fent, Coordinator of Continuing Medical Education, MSMS, 120 W. Saginaw St., East Lansing, 48823. Be sure to include a $3 administrative charge.

Choose the correct answers (more than one answer may be correct).

1. The following are thought to be generally accepted reasons for the dramatic rise in genital herpes cases:

A. Increases in the use of oral contraceptives.
B. Oral Sex.
C. A Communist germ warfare plot.
D. Increases in the number of sex partners.
E. Decreases in the use of barrier contraceptives.

2. The signs and symptoms of a primary herpes infection may include:

A. Tingling, burning, pain as a prodrome.
B. Enlarged and tender lymph nodes.
C. Fever.
D. Malaise.
E. None of the above.

3. Pregnant women with history of herpes below the waist or who have a sex partner with a history of genital herpes:

A. Need to be followed carefully during pregnancy.
B. Should have cervical and vaginal cultures done regularly during the last part of pregnancy.
C. Will need a caesarean section if the virus is present just before birth.
D. Will always deliver an infant with neonatal Herpes Simplex.
E. Can be reassured that with education, and proper pre and post natal care, her baby will most likely be healthy.

4. The following may be recommended to people with a history of recurrent cold sores:

A. Avoid kissing loved ones from the onset of the prodrome till the scab falls off.
B. Avoid oral-genital sex from the onset of the prodrome till the scab falls off.
C. Wash your hands upon awakening, before rubbing your eyes.
D. Drink out of your own glass when a cold sore is active.
E. Never have sex.

5. Highly effective treatments for cold sores and genital herpes include:

A. Vitamin A
B. Zinc
C. Dye-light treatments
D. BCG
E. None of the above

True or False:

6. It is scientifically accurate to call cold sores herpes 1 and genital lesions herpes 2. **T F**

7. University health center studies showed that ⅔ of genital herpes lesions are caused by Herpes Simplex Virus type 1. **T F**

8. The primary herpes infection may last three weeks. **T F**

9. The leading cause of infectious blindness in this country is Herpes Keratitis. **T F**

10. Everyone who has a primary herpes infection will suffer reoccurrences throughout life. **T F**

11. Women with a history of genital herpes should have a pap smear twice a year. **T F**

12. Adenine arabinoside can be effective in reducing morbidity and mortality, when given early in the course of herpes encephalitis. **T F**

13. Those at special risk for developing a widespread and sometimes fatal herpes infection include transplant patients and those on chemotherapy for other diseases. **T F**

14. Asymptomatic carriers of herpes are seen more often in men than women. **T F**

15. Antibiotic ointments are the best thing to use on cold sores and genital herpes lesions. **T F**

16. Idoxuridine and adenine arabinoside are two antiviral agents that are effective in herpes eye infections if treatment is started early. **T F**

I wish to apply for one hour Category I CME Credit through the MSMS Committee on CME Programming. I have read the article and completed the quiz. I understand that my answer sheet will be graded confidentially, and that notification of my successful completion of the quiz (80 percent of the questions answered correctly) will be sent to me. I also understand that if I do not answer 80 percent of the questions correctly, I will not be eligible for the one-hour Category I Credit, but may record and/or report the activity in Category V.

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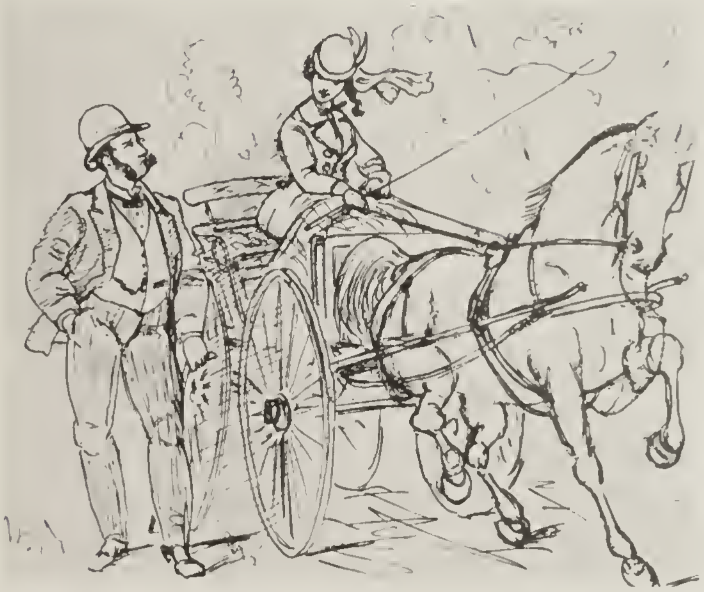
Women physicians — expanding the domain

By Rhoda Powsner, MD, JD
Ann Arbor



The chagrin with which male physicians in the 1800s viewed their female "competition" is captured in this Charles Ellery Stedman notebook drawing of June 24, 1875. From the *Records* of the Dorchester Medical Club. Courtesy of the Boston Medical Library in the Francis A. Countway Library of Medicine, and as printed in *Doctors Wanted: No Women Need Apply*, by M.R. Walsh, New Haven: Yale University Press, 1977.

This past winter E. Grey Dimond, MD, wrote a spirited editorial in *JAMA* exhorting women physicians to meet the challenge of their dual careers. Reacting to so-called feminist concerns that women simply cannot achieve equality in medicine because of society's expectations about their performance as wives and mothers, Dimond advised women physicians to learn to delegate their responsibilities at home to facilitate their medical careers.

In a companion editorial, Marilyn Heins, MD, discussed a number of problems facing women physicians, including the nature of the difficulties encountered by those attempting to ascend the academic ladder. If the medical community as a whole had not been aware of the problems encountered by women physicians previously, these editorials provided insight into issues that will be debated more fully over the next decade.

Other obstacles

Even casual observation reveals that in addition to the practical considerations involved in reconciling home, family and career, women physicians face another set of obstacles, which actually may be far more difficult to conquer. These are the psychological and stereotypical barriers which must be surmounted as women enter what has been essentially a masculine domain.

The percentage of women medical students today exceeds that for any period since the 1890s. There is no rational basis for the presumption that the performance of these women will be inferior to that of their male colleagues; nevertheless, there continues to be the inference that this will, indeed, be the case. The bases for tenaciously held negative expectations, which dare acceptable levels of achievement, bear some scrutiny.

The origins of these negative expectations are not immediately apparent from historical documents, since recorded history contains little information about women's cultural impact and involvement through the ages. One might easily conclude biology was, indeed, destiny were it not for anecdotal information indicating that women have been active participants in societal activities other than, or in addition to, childbearing and childrearing. Moreover, from this anecdotal information, it is obvious that women have been engaged in a continuing struggle for educational, political and social equality.

During the Middle Ages, which was the only period when single women were accorded special status as a consequence of their dedication to the church, there were probably more literate women than men. By the time of the Renaissance, wealthy Italian families were educating their daughters in classics, philosophy, math and science. Professorial appointments were granted to outstanding women scholars. While middle class women of this era did not receive formal education, many taught themselves Greek, Hebrew and Latin as part of their involvement in family printing businesses, which flourished with the invention of movable type. Work and family life were not mutually exclusive. Laura Bassi, a professor of physics at the University of Bologna, was the mother of 12 children. The women printers were successful entrepreneurs as well as wives and mothers.

That the married professional woman of the twentieth century, juggling the various sectors of her life, is no new phenomenon in history is clearly shown in the lives of these women, many of whom both printed and sold books, managed with credit complex literary estates, continued the process of self-education needed to carry on the business, and meantime reared large families — as their wills clearly show.

Almost the only glimpse of their private lives comes from those wills. Certainly they took time out from business to keep house, for with what scrupulous feminine precision they distribute not only their valuable printing businesses, but their household goods — silver platters and

Continued on page 484

Doctor Powsner is both a lawyer and a physician, serves as an alternate delegate to the AMA and is on the advisory committee to the Michigan Medical Arbitration System. She also is editor of the Washtenaw County Medical Society *Bulletin*.

candlesticks, featherbeds, bolsters and sheets, even the "best gowne and petticote." And even in their wills they keep a solicitous maternal eye on their offspring. Joan Wolfe in 1574 leaves an annuity for her son, "provided alwaies that the saide Henrye . . . applie his studdye at the universitie."
(Gies D. Some Early Ladies of the Book Trade)

Profound change

But the advent of Luther and Calvin caused a profound change in the role and activities of women. Mary was, in essence, dethroned: many convents, which had offered educational opportunities to women, were closed. Marriage became the only truly acceptable state. In contrast to the earlier expansion of women's domain, the era of Protestantism and Puritanism saw the contraction of many, and the emergence of only one new socially acceptable role — that of parson's wife. With reinforcement of the patriarchal structure of the family, education for women and activities outside the home were sharply curtailed. Equality between the sexes existed only among the Quakers.

For a period of the next several hundred years there was little impetus for the expansion of woman's role in society. Women were expected to be, first and foremost, obedient to the men in their lives, and since it was feared that education would cause women to lose their feminine attributes, lone voices raised in behalf of expanding their educational opportunities were not well received. The writings of Moliere, Rousseau and Daumier reflect the ambient cultural attitudes.

When Mary Astell suggested in 1695 that English noblewomen be exposed to literature, philosophy and languages to better prepare them for marriage, she was vigorously denounced by the clergy. Sir William Blackstone in his *Commentaries on the Laws of England* published in 1765 characterized married women as virtual non-entities: "the very being in legal existence of the woman is suspended during the marriage. . . ." Small wonder that Hugh Walpole dubbed Mary Wollstonecraft, the author of *A Vindication of the Rights of Women,* "a hyena in petticoats." Wollstonecraft's work, published in 1792, was to serve as the primer for the woman's reform movement.

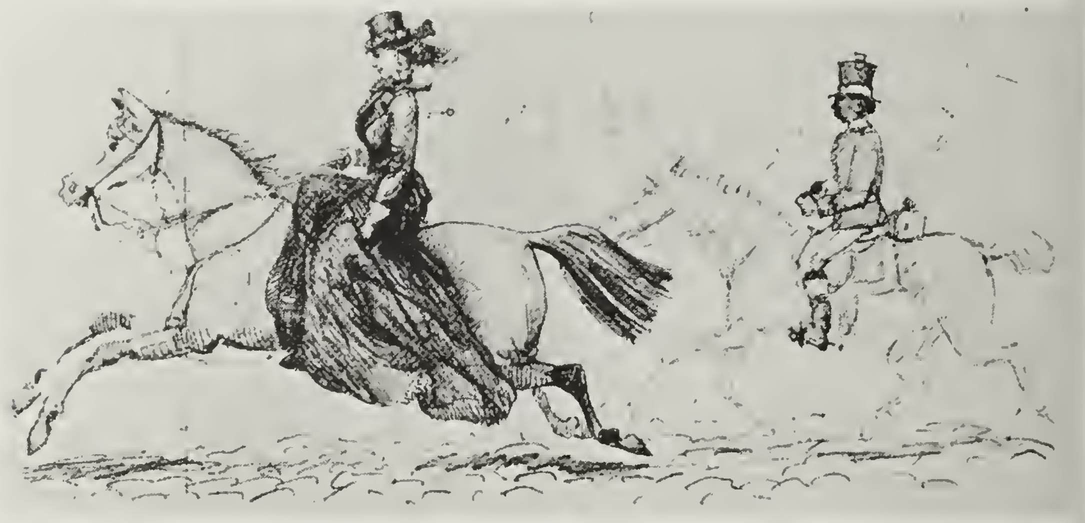
Contrary to popular beliefs about colonial America, men and women were not political and social equals. America, the symbol of freedom from oppression, not only failed to provide equal educational opportunity and voting rights to women, but it carried the subjugation of women imposed by the Reformation one step further. A compulsion to justify the decision not to grant women equality resulted in a plethora of rhetoric describing woman's incapacities, both physiological and psychological. The educational process was deemed too stressful for the fragile female psyche.

In addition, the social architects of the period found it very comfortable to define the world in terms of two spheres or domains: the home, which belonged to women; and all the world outside the home, which belonged to men. The division was felt to be so distinct and inherently correct that nothing, certainly not education, should be expected to bridge the gap.

This compartmenting of the world into male and female spheres and the attitudes it fostered has probably been the most difficult hurdle for women to overcome in the quest for personal and professional acceptance.

With the Industrial Revolution came a marked change in family life. Men left the farm for work in more urban areas, and lower class women changed the focus of their activities from the home to low paying factory jobs. Middle class women, on the other hand, became virtual prisoners in their homes, immersed in the "cult of womanhood:" piety, submissiveness, purity and domesticity. Not surprisingly, the rigid demarcation of the world into male and female spheres became more and more difficult to maintain.

In addition to the outside activities of poorer women, the very considerable talent of middle class women, who were confined to their domain, the home, was ripe for constructive expression. Slavery, the burning social issue of the period, had captured the interest of these women. In keeping with the social structure of the time, women's participation even at the world anti-slavery conference in London was limited to that of spectator behind curtains, to conceal their very presence.



Again, Charles Ellery Stedman's notebook drawing of March 25, 1878 depicts a dashing and prominent female physician of that era. This illustration, too, is from the Walsh book.

Feminist movement

Confined to the home, excluded from equal participation in the political arena, distressed by the double standard of morality, and appalled by male monopolization of all means of profitable employment, American women of the middle nineteenth century were ready to launch a feminist movement. In 1848, Elizabeth Cody Stanton and Lucretia Mott, two women who had observed the earlier world anti-slavery conference from behind the curtains, called a conference in Seneca Falls, New York to discuss the social, religious and civil rights of women.

With the advent of the feminist movement, previously isolated ac-

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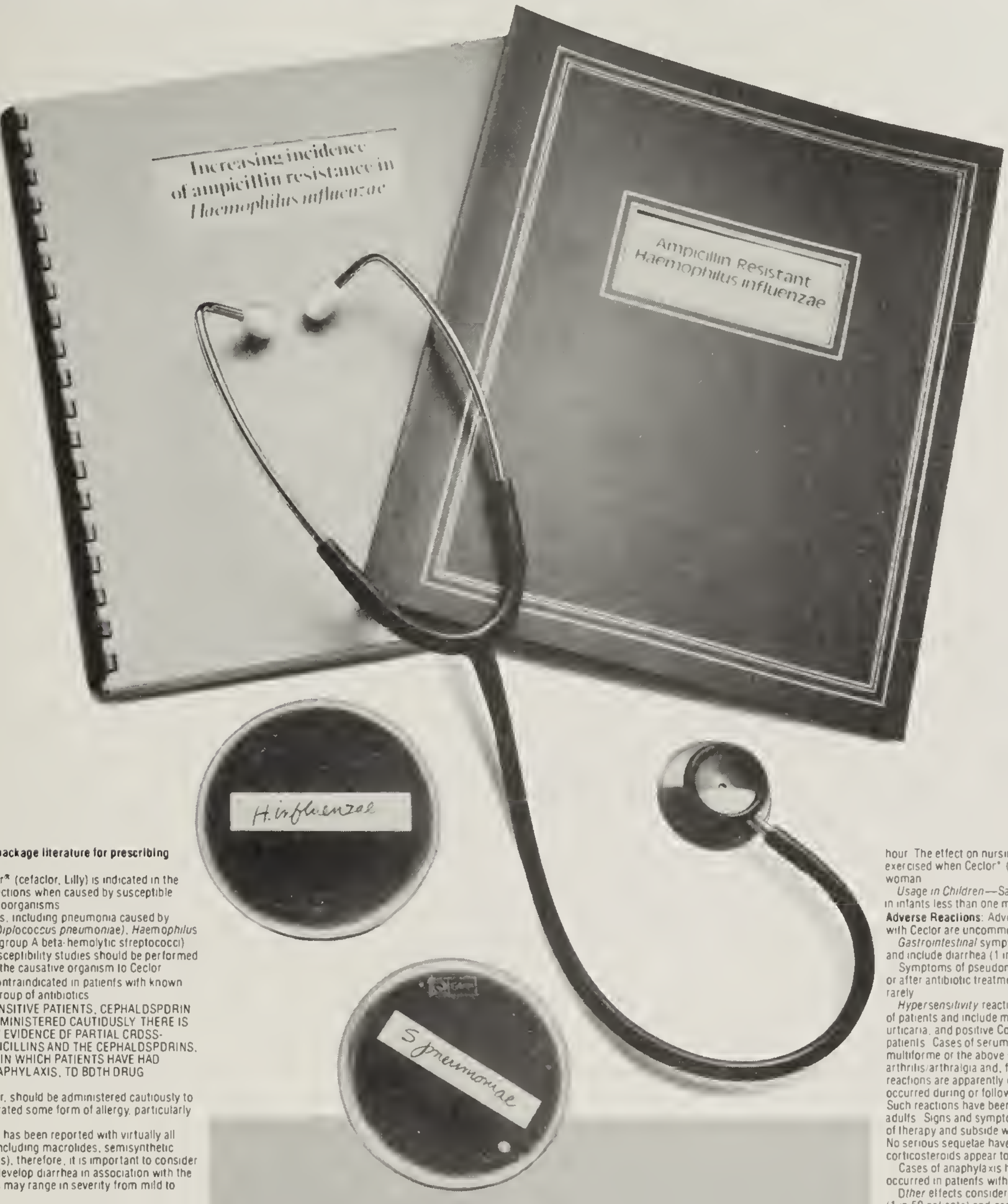
An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by C *difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary the patient should be treated with appropriate agents, e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother s milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequetae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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Additional information available to
the profession on request from
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The Stawskis flank Sen. Paul Henry (R-Grand Rapids) on the Senate floor, center.

Doctor Stawski's visit to Lansing reveals complexities of lawmaking decisions

By Carole Eberly
East Lansing

It's almost 9:15 in the morning.

Lawmakers, aides, reporters, lobbyists and onlookers mill around a sparsely-decorated, beige-carpeted room barely big enough for the T-shaped table where the House Judiciary Committee members will sit. Extra folding chairs are hurriedly put up for the overflow crowd. It's every one for himself as the chairs disappear.

Sandwiched in the corner is Willard (Bill) Stawski, MD, Grand Rapids, his trenchcoat neatly folded in his lap. He and his wife, Elvira, pore over the bill up for consideration. Soon the chairman walks in and discussion begins on the legislation that would designate agents to make medical life and death decisions for individuals.

More excited

Doctor Stawski, s surgeon, is the MSMS Physician Legislative Network representative this week as part of the MSMS program to bring doctors and lawmakers closer together.

He'll put in a full day and come out more excited about Michigan's legislative process than when he went in. Even the continual pouring rain outside doesn't dampen his spirits.

"I wish everyone in Michigan could do this," he later says of his experience.

Just 30 minutes earlier the Stawskis were finishing breakfast at a quiet, near-empty Lansing restaurant.

Kevin Kelly, MSMS legislative liaison, munched on an English muffin and mapped out the day for them. Kelly will act as their guide for the day.

He explains the committee meeting in the morning.

"After that we'll go to the Senate floor where Sen. Paul Henry (R-Grand Rapids) will take care of you. Then we'll have lunch with four of your legislators. And finally, you'll sit in the balcony of the House to watch what's going on there."

Whew!

Kelly, whose enthusiasm is contagious even at this early hour, hands

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Ms. Eberly is a Lansing-area freelance writer.

Continued on page 488

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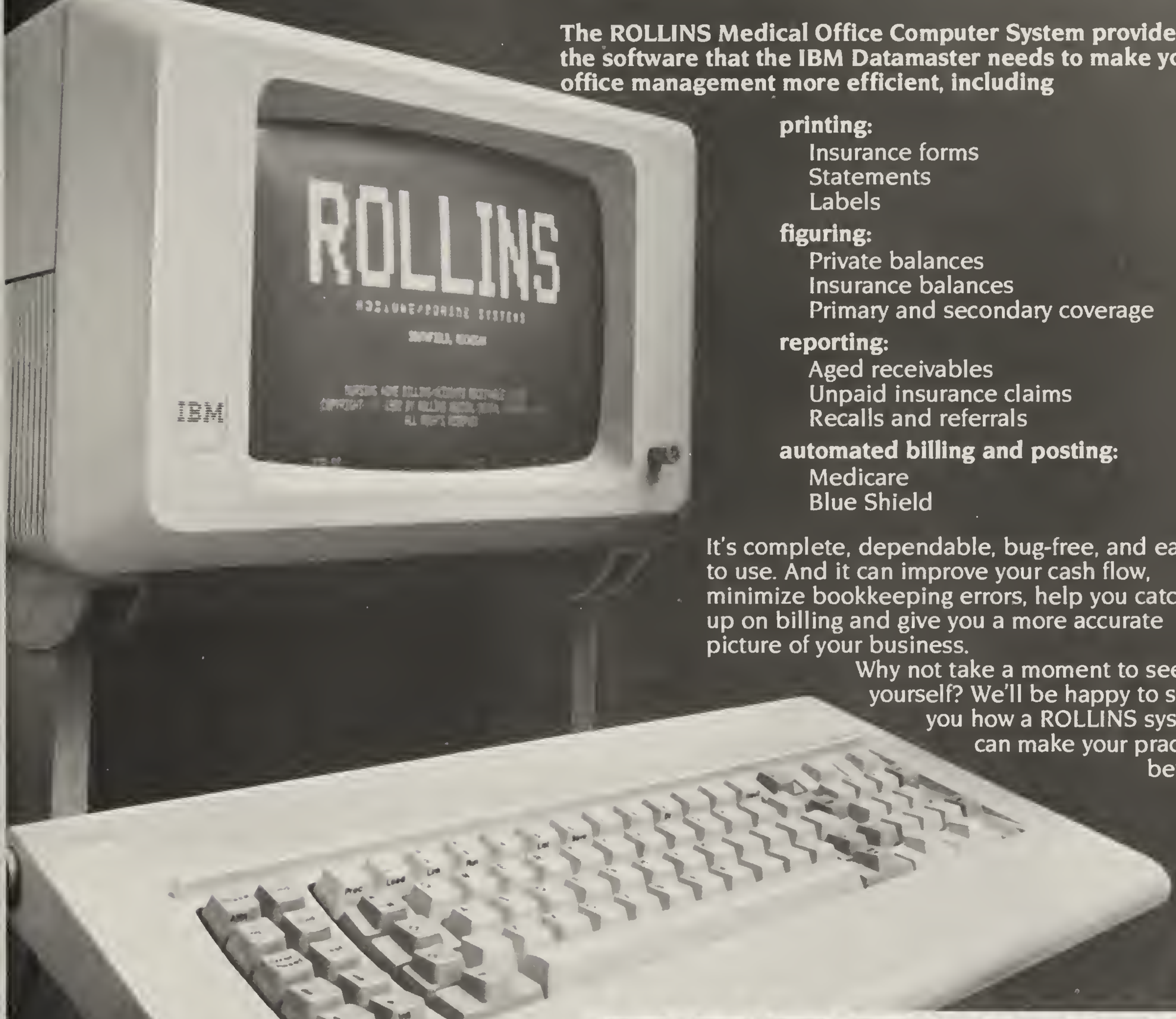

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MICHIGAN STATE MEDICAL SOCIETY 18 66

Doctor Stawski (foreground) and Kevin Kelly at the end of the day in the House balcony.

out booklets with pictures and backgrounds of the 148 lawmakers, making identification easier. His attention to detail is apparent throughout the day. The Stawskis were on time everywhere during the hectic schedule, the lawmakers were friendly and informative, the lunch was good.

Really invigorates

"This really invigorates me to be a part of this," he said. "We're hoping to develop professional respect on both sides with this program. And I think we're succeeding.

"When physicians are able to see the day-to-day workings of the legislature, they're aware legislators are really doing something all day. Likewise, the legislators become aware of some problems physicians have.

"I have a lot of respect for the system and so do the legislators. They are pleased to show their day's work. Physicians also are able to realize that legislators are reasonable persons."

Kelly said the program is in operation when the legislature is in formal session, usually from January through June and September through November.

The Stawskis finish their breakfast.

"I'm really looking forward to this," says Doctor Stawski, a relaxed, affable and attentive man.

The only other time he'd been to the Capitol was during a grade school visit as a youngster from Caledonia. He's sure it's changed a lot.

Elvira, an attractive, outgoing woman who met her husband at the University of Michigan while a medical student herself, wouldn't have missed this day for anything — even if it meant intricate planning for the care of their four children coming and going at home in their absence. A native of Latvia, Elvira moved with her family as a child from Germany to this country. She wanted to see democracy in action today.

The Stawskis did.

Meanwhile, back in the committee, a lawyer gives his opinion of the bill. Some persons listen intently, others stare at the ceiling. A secretary delivers coffee to committee members. A lawmaker ignores the "No Smoking" sign and lights up. A spectator huddles with a reporter and talks of his first-hand experience of having a mother who is terminally ill and the red tape involved. He has a three-inch thick file of legal documents under his arm.

Doctor Stawski leans forward to hear the attorney. He goes on and on.

Kelly stands up, signaling time for the Stawskis to leave. The Senate is ready to convene.

Senate busy

Doctor Stawski and his wife are met by Sen. Henry near the three-foot-high wooden swinging doors which separate a small red-carpeted Senate lobby from the rest of the corridor. They are led down a side hallway, through the Senate post office, into the high-ceilinged chamber.

Henry calls for two chairs to be placed next to his desk in the middle of the chandelier-lighted room.

The presiding officer of the Senate — a Detroit legislator — and the Senate clerk drone on and on, wading through tedious routine business. They introduce bills, report on committee work, read resolutions. Senators read newspapers, answer telephones, talk in small clumps with each other.

A vote is called for. Chimes ring and the vote board is unlocked. Magically, papers are put aside, phones placed on hold, the clumps disperse. Then green lights flash up on the board. Once again newspapers reappear, phones reconnect, clumps rejoin.

"It amazes me they know what's going on," Doctor Stawski said. "It seems so confusing."

Third reading of the bills is announced. Doctor Stawski and his wife are ushered to a small ante-room at the rear of the chamber. No visitors are allowed on the floor during this time.

On third reading, final debate is heard and final votes taken on bills. The lawmakers want no distractions then.

The debate is over amendments to a bill that would put stiffer penalties in the law for kidnapping your own children in the case of custody disputes. After 20 minutes, a vote is taken. It loses. Backers jump up and move to put the issue back on the calendar for reconsideration the following week. They'll work (successfully, it turns out) to scrape up the votes for passage.

As the Doctor Stawskis find out, few things ever die in the legislature. They just keep coming back — next week, next month, next year. If you live long enough, most everything passes your way in various forms dozens of times.

A seemingly routine resolution declaring a day of prayer in Michigan is suddenly not routine. The debate picks up steam. It's apparent lunch will be delayed for the senators.

The Stawskis carpool-it with Kelly to the City Club — an elegant former German restaurant three blocks from the Capitol. Inside the restaurant, a favorite with politicians, legislators, government workers and lobbyists, conversations center on government and politics. It's no different at the physician's table.

"There are so many sides to any one issue," Doctor Stawski says to

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The Stawkis (at rear of photo) observe the House Judiciary Committee in session.

Reps. Vernon Ehlers, R-Grand Rapids and Victor Krause, R-Rockford, at his table. "Everyone seems to have his own opinion. When you listen to them, they all make sense. It's got to be so difficult to make up your mind on all of this."

Doctor Stawski also observes that such situations, where there is no clear-cut right and wrong, would make it easy for an opponent to pick apart an incumbent's voting record.

"Nothing is cut and dry," he says.

Sens. Henry and Dick Posthumus, R-Lowell, show up as orders are taken for soup, salads and sandwiches. A rehash of the kidnapping bill and the prayer day resolution take place. Local school issues, reapportionment and farm matters work their way into the conversation between bites of food.

Kelly, sitting at the head of the table, looks at his watch. It's 1:30 — time to get moving, as the House convenes at 2 p.m.

House chaotic

Following a short meeting with Ehlers in his Capitol office, the Stawskis find their way to the House balcony.

An opening prayer is said — just about the only time there is silence in the chamber. Where the Senate can be described as busy, the House is near-chaotic with lawmakers, aides, reporters and assistants bustling about.

"I just can't get over how they know what's going on," Doctor Stawski says.

"Their days are just packed. There's always something going on."

Doctor Stawski, who took the day off to participate in the program, says it was well worth it.

"Oh, I wouldn't have missed this for anything," he said. "It's truly been exciting. I really have a good feeling about our government after being here."

He also said it pointed out that the world does not revolve around physicians. There are times, he said, when doctors lose sight of that. A visit such as he experienced puts it all into focus, he said.

Would Doctor Stawski consider politics for himself?

"No way," he laughed.

"I'm content to leave that to them," he said, gesturing to the House floor. "We're well taken care of."

**See page 494
for application
to participate
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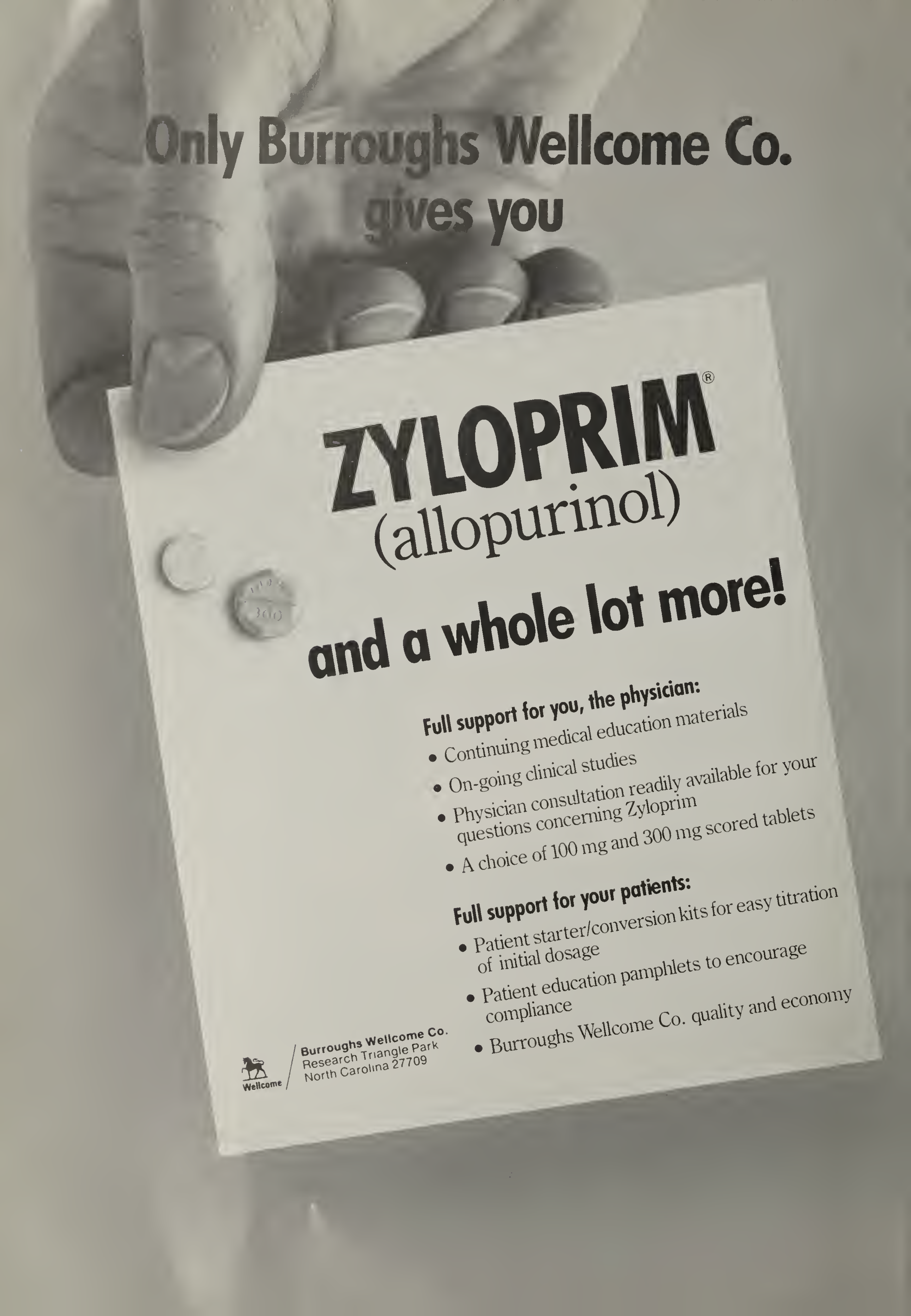

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MSMS delegates, alternates, guests and staff gathered in the Hubbard Ballroom of the Hyatt Regency Dearborn during the 1983 MSMS House of Delegates meeting for the annual Michigan Doctors Political Action Committee Luncheon. The luncheon is a highlight of the MDPAC year, which will pick up momentum again in September. MSMS members are urged to take an active part in their PAC, which works closely with the MSMS Physician Legislative Network. A form for arranging active participation with the network follows on the next page.

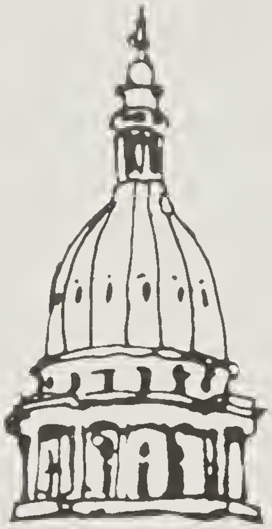
1983 MDPAC Luncheon highlights

BERGLUND
OWEN

At the head table at the MDPAC Luncheon were, from left, Thomas R. Berglund, MD, Portage, past MDPAC chairman and now secretary of the American Political Action Committee board; Speaker of the Michigan House of Representatives Gary M. Owen (D-Ypsilanti) and MDPAC Chairman Thomas E. Stone, MD, Muskegon.

Another key speaker at the MDPAC Luncheon was Sen. Patrick McCollough (D-Dearborn) right, chatting at left with MSMS Outstate Caucus Chairman James McGillicuddy, MD, Lansing. Sen. McCollough described in detail the five-part omnibus bill he was about to introduce to improve the medical malpractice situation in Michigan.

Here's your opportunity, Doctor, to join MSMS Physician Legislative Network



Many MSMS members are acquainted with important legislators and government officials and are willing to employ this acquaintance to advance the legislative efforts of the medical profession.

The MSMS Department of Government Relations maintains a list of these members and calls upon them for assistance when the need arises.

If you are willing to participate in this program, either "back home" or in Lansing, MSMS invites you to fill in the form on this sheet, as appropriate, and return to Kevin Kelly at MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823. This information will be held confidential and used only by MSMS in its contacts with you.

______ I'm interested in working with the "MSMS Physician Legislative Network"
NAME:______________________________
ADDRESS:______________________________
PHONE # HOME:__________ OFFICE:__________ HOSP:__________
TYPE OF PRACTICE SETTING:__________ SPECIALTY:__________
HOSPITAL AFFILIATION IF APPLICABLE:__________
MEMBERSHIP IN SPECIALTY SOCIETY:__________
OFFICES HELD, COMMITTEE INTERESTS:__________
____

PLEASE INDICATE THE DISTRICTS IN WHICH YOU ARE REGISTERED TO VOTE:
CONGRESSIONAL:__________ STATE SENATE DISTRICT:__________
STATE HOUSE DISTRICT:__________

I AM PERSONALLY ACQUAINTED WITH THE FOLLOWING LEGISLATORS: (Please list only those legislators you are willing to phone, write or personally contact.)

EXTENT OF RELATIONSHIP
(Personal friend, worked on campaign.........)

STATE REPRESENTATIVE(S):__________ - __________
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STATE SENATOR(S):__________ - __________
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OTHER GOVERNMENT OFFICIALS:__________ - __________
__________ - __________
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______ I would also be willing to come to Lansing in order to help MSMS Legislative efforts. PLEASE COMPLETE THE FOLLOWING: Number of hours needed to reach Lansing:________
Amount of advance notice required prior to an MSMS request for you to "visit" Lansing:______

Please check those areas in which you have a personal and/or professional interest, which you feel you would be most effective in discussing with a legislator, or could present as testimony to a committee of the legislature.

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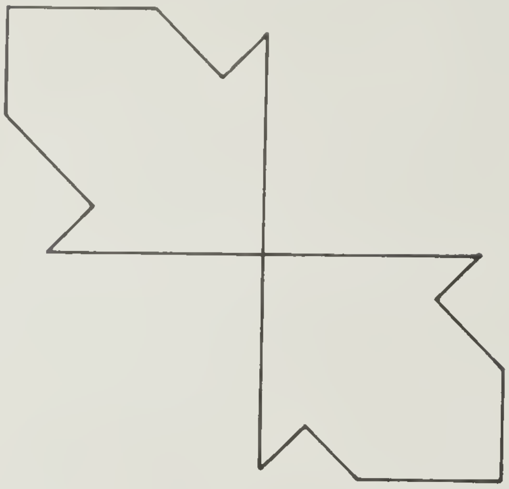
MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

Sept. 10-11 — "Impact of Lifestyles on Child and Adolescent Health Problems, "cosponsored by the AMA and the Illinois State Medical Society, Chicago Hyatt Regency Hotel, contact: Michael Cherskov, AMA, 535 N. Dearborn, Chicago 60610, (312) 751-5458.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14). MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 4-5 — "Fall Festival of Knowledge," Fall Leadership Seminar, American Association of Medical Assistants, Michigan State Society, Sheraton Fashion Square Hotel, Saginaw, contact: Caroline Rich, MSMS headquarters.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherrry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Feb. 4-5, 1984 — "Through the Looking Glass," American Association of Medical Assistants, Michigan State Society, Mid-Winter Seminar, Amway Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

March 29, 1984 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

May 4-6 1984 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact Warren Tryloff, MSMS headquarters.

Other Meetings

August 19-21 — 1983 Congress, Michigan Association of the Professions, Sugar Loaf Mountain Resort, Cedar, contact MAP, 1407 S. Harrison Road, Suite 350, East Lansing 48823.

August 21-25 — Pharmacy 100 — Anniversary Convention Celebration, Michigan Pharmacist Association, contact: MPA Educational Center, 815 N. Washington Ave., Lansing 48906.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

Sept. 22-23 — Third Annual Conference, Society for Public Health Educators, Great Lakes Chapter, Holiday Inn, Mount Pleasant, contact: Rhonda Rush, Van Buren County Health Dept., P.O. Box 307, Hartford 49057, 616/621-3143.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118, (617) 266-9703.

Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209, (703) 528-6405.

November 9-13 — American Medical Women's Association Annual Meeting, Hyatt Regency, Dearborn, contact: Meeting Coordinator, AMWA National Office, 465 Grand Street, New York, NY 10002.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 11 — 1983 Annual Meeting, American Medical Women's Association, Dearborn, contact: Carol Meyers, 465 Grand St., New York, NY 10002, (212) 533-5104.

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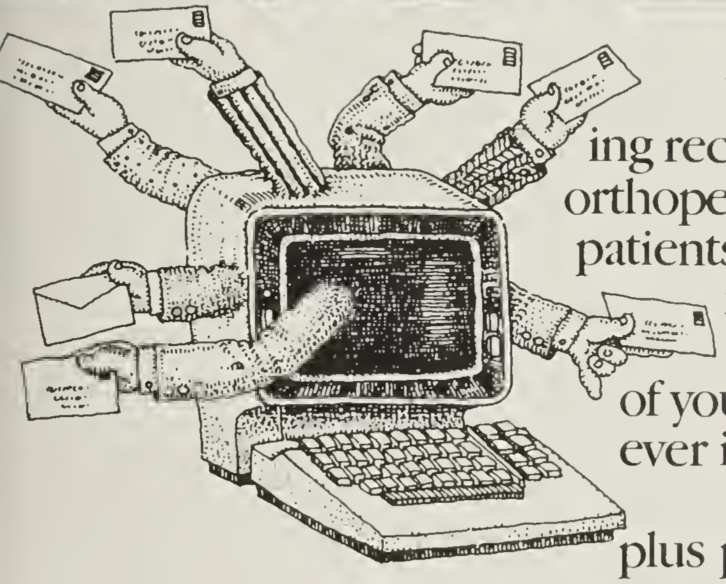

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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: Aug. 20-21, Regional Anesthesia: Anatomy and Techniques. Location: Gordon Scott Hall, Detroit Medical Center. **Sponsor:** WSU School of Medicine Departments of Anesthesia and Anatomy. **Cost:** $260. **Contact:** WSU School of Medicine, Division of DME, 4H DRHUHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: Aug. 26-29, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and The Division of Infectious Diseases, Department of Internal Medicine. **Cost:** $275. **Contact:** Office of CME, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: September 5-19, European Tour in Conjunction with 7th International Congress FIMM (Federation Internacionale de Medicine Manuelle). Contact: Sandra Kilbourn, MSU-COM, (517) 353-9714 for registration and credit information.

Date: September 12-16, Basic Muscle Energy Tutorial. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 14, Colorectal Cancer: Essentials for Physicians and Nurses. Location: Park Place Hotel, Traverse City. **Sponsor:** American Cancer Society. **Cost:** Physicians — $30; Students/Nurses — $15. **Contact:** American Cancer Society, North Central Area Office, 401 W. Front St., Traverse City 49684, 616-947-0860. **Approved for:** 6 hours of Category I Credit.

Date: Sept. 19-21, Diabetes Update: 1983, Symposium and Workshop. Location: Towsley Center for CME, U-M Medical School, Ann Arbor. **Sponsor:** U-M Medical School Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Division of Endocrinology and Metabolism, Department of Internal Medicine and The Michigan Diabetes Research and Training Center. **Cost:** $245. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 19 hours of Category I Credit.

Date: September 21, The Primary Physician & Cancer Management. Location: Kalamazoo Center Hilton Inn. **Sponsor:** American Cancer Society, Kalamazoo County Unit. **For:** Primary care physicians. **Cost:** $25. **Contact:** American Cancer Society, Kalamazoo County Unit, 123 E. Kalamazoo Ave., Kalamazoo 49007. **Approved for:** 7 hours of Category I Credit.

September 24, Perspectives on Inflammatory Bowel Disease. Location: Somerset Inn. **Sponsor:** Henry Ford Hospital, Office of CME. **Cost:** $100. **Contact:** Medical Education Office, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3072. **Approved for:** 6 hours of Category I Credit.

Date: Sept. 26-28, Advances in Emergency Care. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **Contact:** Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing, 48823. **Approved for:** 9 hours of Category I Credit.

Date: Sept. 29-Oct. 1, New Perspectives in Cardiac Imaging. Location: Hyatt Regency, Dearborn. **Sponsor:** Professional Education Committee of the Michigan Heart Association, and Council on Clinical Cardiology of the American Heart Association. **Contact:** Eleanor D. Peterson, RN, Program Consultant, Michigan Heart Association, 16310 W. 12 Mile Road, PO Box 160-LV, Lathrup Village 48076, (313) 557-9500. **Approved for:** 17 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 3, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 32 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Newer Intravenous Anesthetic Agents and Medicolegal Update. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** U-M Medical School, Office of CME, Depart. of Postgraduate Medicine and Health Professions Education, The Department of Anesthesiology and The Michigan Society of Anesthesiology. **Cost:** $125. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: October 1-2, Burns Clinic 11th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center, P.C. **Cost:** $120. **Contact:** Philip E. Hill, MD, Chairman, Burns Clinic Medical Center, PC, Petoskey, MI 49770, (616) 348-4500.

Date: Oct. 3-7, Advanced Muscle Energy Tutorial (above diaphragm). Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: October 7-9, 5th International Congress of Laser Medicine and Surgery. Location: The Westin Hotel, Detroit. **Sponsor:** Sinai Hospital of Detroit and the International Society of Laser Medicine and Surgery. **For:** Cardiovascular, Endoscopy, General Surgery, Gynecology, Instrumentation/Biomedical Research, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic, Otolaryngology, Photo-Biology, Plastic Surgery/Dermatology, Podiatry, Urology. **Cost:** $345 before 8/30, $380 after 9/1, $300 Post Grad Med Resident. **Contact:** Fifth International Congress of Laser Medicine and Surgery, % Charles B. Slack, Inc., Registration Supervisor, 6900 Grove Road, Thorofare, NH 08086, (609) 848-1000. **Approved for:** 18 hours of Category I Credit.

Date: October 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand and the International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Bldg., 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 1-3, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109, (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: November 12, Borderline Patients: Psychoanalytic Perspectives. Location: The Michigan Inn, Southfield. **Sponsor:** Michigan Psychoanalytic Society. **Cost:** $60. **Contact:** Michigan Psychoanalytic Society, 16310 W. Twelve Mile Rd., Suite 204, Southfield 48076. **Approved for:** 6 hours of Category I Credit.

Date: November 13, Sixth Annual Pediatrics Conference. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, MI 48824, (517) 353-8822. **Approved for:** 6.5 (applied for only) hours of Category I Credit.

Date: November 18-20, Manual Medicine to the Extremities. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents principles of manual medicine with emphasis on diagnosis and manipulative management of extremity problems. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: December 5-9, Basic Principles of Manual Medicine. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents lectures, demonstrations, and practice sessions on the spine, pelvis, and extremities. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: December 10, December Seminar, Michigan Society of Pathologists. Location: Rackham Auditorium, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

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DATES AND LOCATIONS

Tuesday, September 27, 1983
Amway Grand Plaza Hotel
Pearl at Monroe Streets
Grand Rapids, MI 49503

Wednesday, September 28, 1983
Bay Valley Inn
I-75 at M-84
2470 Old Bridge Road
Bay City, MI 48706

Thursday, September 29, 1983
Hyatt Regency - Dearborn
Fairlane Town Center
Dearborn, MI 48126

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Continued on page 502

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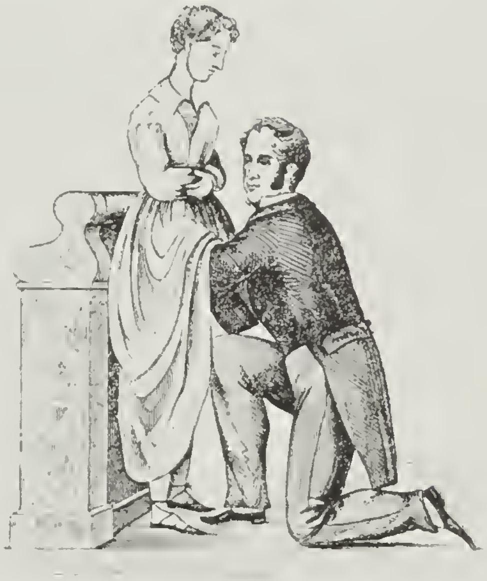
tivities, especially in those areas of great concern, coalesced. One such concern was the questionable nature of the quality of medical care available to women. Female modesty and male prurience were recurrent topics in both lay and scientific works of the period. Excerpts from the medical literature suggest that sexual issues were really seriously interfering with medical practice.



The Victorian era's influence on morals brought about this awkward illustration for physicians who treated female patients.

To help combat one obvious aspect of the problem of lack of knowledge about their own bodies, women founded their own physiological societies to learn basic facts about anatomy and biology. Subsequently, networks were formed to provide financial and emotional support for women studying at established medical schools. In Boston, where women physicians were excluded from the numerous existing clinical facilities, feminists assisted in the establishment of the New England Hospital for Women and Children to insure adequate training for undergraduate and graduate women physicians.

Attesting to the success of these activities is the fact that 20 percent of the physicians practicing in Boston at the beginning of the twentieth century were women, the majority of whom were managing the dual careers of medicine and families.

Re-hashing

Why, then, are we today still hashing and re-hashing the question about whether or not women can succeed in medicine and whether or not our resources are being wisely spent on their education?

There are many theories about why women physicians' gains in the nineteenth century were dealt such a critical blow by the political, social and economic occurrences of the first half of the twentieth century; however, one explanation encompasses them all.

Women, generally, have been in a secondary position politically and economically. In our intensely competitive society a power base is essential to success, especially when old dogma is being challenged. Historically, women have made great strides in medicine when external forces such as the feminist movements and the two world wars dramatized the need for women physicians. When the external pressure subsided, women's role in medicine became virtually non-existent, since there was no compelling force to allow women to function outside the confines of their traditional domain.

In the year 1983 the question really facing us is not whether women can or should be physicians, but whether in the latter half of the twentieth century, the rigid boundaries defining the sphere of male and female activities, our legacy from earlier times, have been relaxed enough to permit women to pursue personal and professional activities on an equal basis with men.

Miscellaneous

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DEATHS

George E. R. Anthony, MD
Port Lambton, Ontario

George E. R. Anthony, MD, formerly of Flint, died June 2. He was 77. Doctor Anthony, 1960 president of the Genesee County Medical Society, was former chief of pediatrics at both St. Joseph and McLaren General hospitals. He earned his medical degree at the University of Toronto in 1930, then maintained a practice in the Flint area for almost 40 years. Doctor Anthony was a member of the American Academy of Pediatrics, the Detroit Pediatric Society, the Flint Academy of Medicine, and was a major in the US Army during World War II.

James H. Fyvie, MD
Manistique

James H. Fyvie, MD, Manistique, died May 24 at the age of 74. Doctor Fyvie, a 1936 graduate of Rush Medical School, University of Chicago, was a civic leader. He was honored at a community banquet in 1963 for his service as mayor, school board member, planning commission and city council member, and youth athletic director. Doctor Fyvie had been an industrial physician at Inland Limestone Company, and at area railroad companies. He had been recognized as a distinguished alumnus of Olivet College, and was a member of the American Academy of General Practice, the AMA Rural Health Committee and the UP Medical Association. Doctor Fyvie served as a major in the US Army in Europe from 1942 until 1946.

Fouad W. Kai, MD
West Branch

Fouad W. Kai, MD, West Branch, died May 24 at the age of 34. Doctor Kai, formerly of Flint, was a general surgeon. He was a graduate of the University of St. Joseph Medical School, Beirut, Lebanon. He did his internship and residency at Hurley Medical Center in Flint, then moved to West Branch to join the staff of Tolfree Hospital. He was a trustee on the medical staff board at the latter institution. Doctor Kai was certified by the American Board of Surgery and was a Fellow candidate.

Francis B. MacMillan, MD
Detroit

Francis B. MacMillan, MD, Detroit, died May 23. He was 81. Doctor MacMillan, a Detroit native, was a 1925 graduate of the Wayne State University of Medicine. He was a past president of the Detroit Society of Surgery for Trauma, and was retired chief of staff at Providence Hospital, Southfield. He had been on staff at the former Detroit Memorial Hospital, and was a member of the International College of Surgeons, and the Industrial Medicine Association.

Lyndle R. Martin, MD
Grosse Pointe

Lyndle Martin, MD, Grosse Pointe, died June 4. He was 80. Doctor Martin had been medical director at Detroit Edison for 34 years, and in 1958 received the company's highest award for protecting and restoring the health of its employees. Doctor Martin had been an associate clinical professor of occupational medicine at Wayne State University. He was a 1931 graduate of the Northwestern University Medical School, and was a member of the Detroit Industrial Physicians' Club, the Michigan Industrial Medical Association, and was a Fellow of the American College of Surgeons.

Edward A. Wishropp, MD
LaJolla, California

Edward A. Wishropp, MD, formerly of Grosse Pointe, died May 18. He was 84. Doctor Wishropp, past president of the Detroit Pediatric Society, was a senior member of the Children's Hospital staff for more than 50 years. A 1926 graduate of the University of Michigan Medical School, Doctor Wishropp was on the board of directors of the American Academy of Pediatrics for ten years. He was on staff at Harper, St. John and Bon Secours hospitals, as well as Children's, and was a member of the Detroit Academy of Medicine and the American College of Physicians. He was a chief medical officer with the US Navy during World War II.

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PRESIDENT'S PAGE

Please contact your legislators to support new malpractice bill

By Donald K. Crandall, MD
MSMS president

Despite hard work by MSMS over the past 10 years to improve the situation, Michigan physicians are on the brink of a new professional liability crisis.

During the last six years, claims have jumped 336 percent, from five per 100 insured physicians in 1977 to 23 per 100 in 1982. The average amount awarded per closed claim has gone up 874 percent, from $4,676 in 1977 to $45,554 in 1982. Hospitals are mandating liability coverage for all staff physicians, and amounts of $1,000,000 liability coverage are being considered.

As you will recall, during the mid-70s the cost of liability insurance for physicians also skyrocketed. Insurance companies were losing great sums of money. Many refused to take on any new physicians, others raised their premiums to relatively high levels, while others stopped doing business in Michigan. The net result was physicians were paying extremely high insurance rates, or were unable to buy insurance at any cost.

That is when MSMS went to work. In the mid-70s MSMS helped get legislation passed that was designed to bring the "malpractice crisis" under control. In addition to the legislative package, additional actions were taken by MSMS to avoid a recurrence of the "crisis."

One of the medical society's first steps was to establish its own insurance company, the Michigan Physicians Mutual Liability Company (MPMLC) to assure continuing availability of physicians' medical liability insurance at a reasonable cost. MPMLC goals are to fight nonmeritorious suits, and to develop a data base to study trends in "malpractice" suits.

MSMS also helped get legislation enacted to establish an arbitration procedure designed to lessen demand on the tort system and dependency upon its inherent high-cost procedures.

MSMS was one of the first state medical associations to establish a program to aid impaired physicians. The program provides timely, effective intervention to prevent the impaired physician from doing damage to patient or profession. In 1981, the MSMS intervention and treatment committee reported 91 cases. In 52 of these the major problem was alcohol, in 25 it was other drug-related dependence, and in 14 psycho-social problems.

The Michigan State Medical Society's constitution affirms its longstanding commitment "to foster and support continuing medical education . . . to stimulate advancement of the science and art of medicine; and to continue to advance the medical, scientific, social and environmental, economic and medical-political knowledge of its members in order that the doctor may better serve patients and the public health generally." In the mid-70s MSMS increased its continuing medical education efforts with its Annual Scientific Meeting, the Michigan Conference on Maternal and Perinatal Health, and numerous other conferences and monthly articles in *Michigan Medicine*.

MSMS has continued its commitment to peer review; first with a PSRO support center, and more recently with the establishment of the Physicians' Review Organization of Michigan (PROM). PROM is a non-profit corporation started by MSMS to provide local peer review under our statewide administration.

Recognizing that physician-patient communication was a key element in malpractice suits, MSMS initiated an educational program for physicians in *Michigan Medicine* to help improve their communication skills.

Communications have also been a part of several conferences held over the past few years. In addition, MSMS has developed radio and TV public service messages to help create better understanding of medicine.

In 1981 the Michigan State Medical Society embarked upon a physician education program to help health care professionals identify risk-laden practices and to abandon them. In September 1982 the risk management committee published a medical course "Professional Liability/Risk Management." The committee is currently doing a study on the effectiveness of risk management training in avoiding malpractice suits.

Because of the impending medical professional liability crisis, MSMS has initiated a five-part legislative package to improve the system and reduce costs. If adopted, the proposal would open the system to more equitable, timely, and objective resolution of claims without jeopardizing the right of medically injured persons to receive just and reasonable compensation.

We expect the legislation to be considered early this fall. Contact by our members with their legislators would be most helpful.

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References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Vol. 82, No. 38 August 18, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

CHIROPRACTORS' SUIT STILL UNOFFICIAL IN MSMS VIEW

Though MSMS members may have been reading about a suit brought against MSMS by the Chiropractic Cooperative Association of Michigan, the suit is not at issue in the eyes of MSMS legal counsel. "The case is totally in the control of the other side," explains Monte Jahnke of the Detroit firm of Kerr, Russell and Weber, MSMS counsel. "To my knowledge none of the parties named by the complaint has been served with summonses, and action does not begin until the defendants have been served." The anti-trust suit, filed in early July in US District Court in Detroit, names 10 medical organizations, including the AMA and MSMS, as defendants. According to the news media, the suit contends that the medical profession has conspired to impede the growth of the chiropractic profession.

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ARBITRATION SYSTEM EVALUATION REPORT DUE IN SEPTEMBER

The first draft of an evaluation of Michigan's medical arbitration system is the topic of two meetings set Sept. 7 and 14 by the Arbitration Evaluation Subcommittee to the Michigan Insurance Bureau's Arbitration Advisory Committee. MSMS representative on the subcommittee is Rhoda M. Powsner, MD, JD, Ann Arbor. The evaluation report is the culmination of a 14-month project conducted by the Institute for Applied Social Research of the University of Michigan to determine whether to continue, improve or eliminate the state's medical arbitration system. The Arbitration Advisory Committee plans to recommend legislative action in the fall.

MALPRACTICE BILLS TOPIC THIS SUMMER OF MSMS, STATE BAR

A subcommittee of the MSMS Committee on State Legislation and Regulations met Aug. 16 to review progress in MSMS talks with the Michigan State Bar this summer on the proposed five-part omnibus medical malpractice bill. The bill was introduced May 2 by Sen. Patrick McCollough (D-Ypsilanti), and is designed to enhance existing medical malpractice laws so that a future crisis in costs of insurance can be avoided. On the subcommittee are James A. Read, MD, Birmingham; Mitchell Rinek, MD, Lansing, and Charles C. Vincent, MD, Detroit.

FORD MOTOR COMPANY INAUGURATING CO-PAY INSURANCE PROGRAM

Ford Motor Company's salaried (non-UAW) employees soon will be covered under a new co-pay health care insurance package. Beginning Jan. 1, those employees will have a plan with a $200 ($250 for a family) deductible feature for most medical expenses (including hospitalization) each year, plus 20 percent of the excess until employee out-of-pocket expenses reach $750. The company seeks to make the employees more aware of their individual impact on health care costs, says Ed Schneider of the Ford News Department, and to make them more comfortable about their catastrophic illness coverage. Employees' coverage is extended past the prior limits of 365 days and the plan pays 80 percent of physician office visits, including initial office visits.

REP. MCNEELY PLANS TO INTRODUCE PPO LEGISLATION

An MSMS panel met Aug. 16 to review proposed preferred provider organization (PPO) legislation before recommending action to the MSMS Committee on State Legislation and Regulations. On the panel are John A. Feemster, MD, Detroit; Mitchell Rinek, MD, Lansing, and B. J. Woodley, MD, Trenton. They anticipate the House Ad Hoc Committee Studying Health Care Costs, chaired by Matthew McNeely (D-Detroit, chairman of the House Insurance Committee), to place legislation before the House of Representatives in September. The panel expects the legislation to permit Blue Cross Blue Shield of Michigan to own and operate PPOs as a separate line of business and to provide for PPOs established by physicians and hospitals, Delta Dental Corporation, HMOs and self-insured employers. Rep. McNeely met several times this month with physicians, hospitals, BCBSM, organized labor, the Michigan Department of Public Health and Michigan Insurance Bureau, to forge PPO legislation.

MSMS PUBLIC AFFAIRS/ LEADERSHIP CONFERENCE TO INCLUDE DR. MANSOUR

Department of Social Services Director Agnes Mary Mansour, PhD, will discuss the DSS role in health care cost control at the Oct. 27 MSMS Public Affairs/Leadership Conference. Other conference speakers will be John McCabe, Blue Cross Blue Shield of Michigan president; Walter Maher, Chrysler Corporation employee benefits and health services director, and Lonnie Bristow, MD, chairman, AMA Council on Medical Services. Location of the conference will be Long's Convention Center, Lansing. Registration forms and further program details will follow in coming issues of Michigan Medicine. For information, you may contact Kevin Kelly or William Madigan at MSMS headquarters.

CAPSULES

William T. Sallee, MD, Farmington ophthalmologist, audited a regular meeting Aug. 10 of the Michigan Board of Medicine. Doctor Sallee's visit was part of a series organized by the MSMS Committee on State Legislation and Regulations to acquaint committee members with the board's workings. . . . Michigan physicians and their guests still may sign aboard that dream Greek Isles Air/Sea Cruise offered MSMS members Oct. 20-31. For details, contact Donna Farougi at MSMS headquarters.

MEDIGRAM
Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Vol. 82, No. 38 August 18, 1983

MEETING SPECIAL!

MICHIGAN MEDICINE

Vol. 82, No. 39 Sept. 1, 1983

Breaking News for Michigan Doctors

MEDIGRAM

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PLAN TO ATTEND ONE OF THESE IMPORTANT WORKSHOPS!

"Improving Your Practice in Today's Competitive Climate"

8:15 a.m.	Registration, coffee and rolls
9:00 a.m.	**"Effective, Efficient Practice Management"** Analyzing your practice situation, staffing, collection policies, patient scheduling, etc. John Anthony, Manager, PSG, Inc.
10:40 a.m.	**"Personnel Pointers for Today"** Personnel policies; legal requirements. Vada Davis, MSMS Assistant Administrator
11:35 a.m.	**"So You're Thinking of Buying a Computer?"** Learning to ask the right questions about your computer needs; leasing vs. buying? using a service bureau? John Anthony, Manager, PSG, Inc.
12:30 p.m.	Lunch
1:15 p.m.	**"Communications — The Key to Patient Satisfaction"** Using medical assistants, newsletters, patient information brochures, the telephone and your office to help you communicate more effectively. Mert Scholten, MSMS Chief of Communications
1:45 p.m.	**"Meeting Medicine's Challenges Today"** A hard look into the future as medicine faces problems within and without. Donald K. Crandall, MD, MSMS President
2:05 p.m.	**"Marketing, Maintaining and Building Your Practice"** What marketing is and isn't; developing a marketing plan; adapting to changing markets; marketing tools. Positioning; increasing visibility; attracting and holding new patients; making networking work for you. Gilbert Harrell, PhD, Professor of Marketing, MSU or Jerry Rosenberg, MD, PhD, Chief of Surgery, Hutzel Hospital

Enroll me in the seminar/workshop indicated below. Enclosed is my check for $55 ($95 for non-members) which covers registration, luncheon, breaks, and all course materials.

____ **Oakland Co. (10/6)**
____ **Detroit (WCMS) (10/13)**
____ **Marquette (10/20)**
____ **Saginaw (Sheraton) (11/2)**

Name ______________________________

Address ______________________________

____

City ____________________ **State** __________ **Zip** __________

Please mail to MSMS, 120 W. Saginaw, East Lansing, MI 48823.
Registrations will be acknowledged with location map, phone number of site.

the

IMPACT

of government & economics on medical practice

Register today!

1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's, Lansing

Berglund, Bristow, Crandall, Killeen, Maher, Mansour, McCabe, McNeely, and Rosenberg — those are the names of the speakers gathered for the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's Convention Center, Lansing.

Each of these outstanding leaders will bring the benefit of their perspective and expertise to help MSMS members better understand the forces shaping medical care delivery today in Michigan.

The emphasis is on the governmental and economic trends forging the medical environment, as perceived by Chairman Fred E. Patterson, MD, and his committee.

Attendees will receive the MSMS book, "Challenge of the 80s: A Guide to Successful Medical Practice."

Make your plans today to attend this excellent briefing on the medical practice world.

PROGRAM

8:30	REGISTRATION
9:00	OPENING REMARKS — Fred E. Patterson, MD, chairman, MSMS Public Affairs Leadership Conference Committee INTRODUCTIONS — Thomas R. Berglund, MD, chairman, MSMS Board of Directors
9:05	PUBLIC, SOCIAL AND HEALTH CARE PROGRAMS — Agnes M. Mansour, PhD, director, Michigan Department of Social Services
9:40	THE ROLE OF BLUE CROSS BLUE SHIELD IN HEALTH CARE DELIVERY — John C. McCabe, president, Blue Cross Blue Shield of Michigan
10:15	HEALTH CARE ISSUES: LABOR'S PERSPECTIVE — Patrick Killeen, senior health care consultant, United Auto Workers Social Security Department
10:45	PRIVATE SECTOR STRATEGIES IN HEALTH CARE COST CONTAINMENT — Walter B. Maher, director, Employee Benefits and Health Services, Chrysler Corporation
11:15	YOUR "CHALLENGE OF THE 80s" — MARKETING YOUR MEDICAL PRACTICE — Jerry C. Rosenberg, MD, PhD, chief of surgery, Hutzel Hospital
12:15	LUNCHEON
1:15	INTRODUCTIONS — Donald K. Crandall, MD, president, Michigan State Medical Society
1:20	HEALTH CARE COST CONTAINMENT: A LEGISLATIVE PRIORITY — Representative Matthew McNeely, chairman, House Insurance Committee; chairman, House Ad Hoc Committee on Health Care Cost Containment
2:00	MSMS INITIATIVES: Donald K. Crandall, MD, moderator Physicians Review Organization of Michigan (PROM) Preferred provider organizations (PPOs) Professional liability Joint venturing and contractual relationships
2:45	A NATIONAL PERSPECTIVE: CRITIQUE OF CHANGING MEDICAL PRACTICE — Lonnie R. Bristow, MD, San Pablo, CA, chairman, AMA Council on Medical Service
3:45	WRAP-UP — Doctor Crandall

On the conference planning committee are Fred E. Patterson, MD, Ann Arbor; Betty Drew, Bloomfield Hills; Peter A. Duhamel, MD, Rochester; Wayne A. Bare, MD, Jackson, and Willard Stawski, MD, Grand Rapids.

1983 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

Please print or type.

Name ______________________________

Address ______________________________

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Name ______________________________

Address ______________________________

For more information:
Please contact William Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351

Please check one

☐ Physician ☐ Other ________

Registration Fee: $35 for luncheon & "Challenge of the 80s" book
$15 — Students & Residents

Amount enclosed $ ________
Please make check payable to Michigan State Medical Society

First Annual Michigan Conference On Well-Being of Physicians

Friday-Saturday-Sunday, October 14-15-16, 1983
Sugar Loaf Conference Center, Cedar

"Stigmatized physician impairment: Sinner, amoral, or diseased?"

(Application has been made for 12 hours Category I CME Credit)

Friday, October 14

5 p.m.	Arrival and Registration
5 p.m.	Dinner (optional)
7 p.m.	"Friday Night at the Movies" Increase your knowledge and improve your intervention skills by viewing "My Brother's Keeper," "Confrontation Strategies for Difficult Doctors," and other excellent instructional films.

Saturday, October 15

10 a.m.	"Getting to Know Yourself" Russell F. Smith, MD, Brighton Take the famous MSMS mini-multiphasic personality profile, basic knowledge test, and other self-revealing exams.
Noon	Lunch
2 p.m.	"Finding and Motivating Impaired Physicians" Russell F. Smith, MD, Brighton What does a chemically dependent or mentally ill professional look like, are these problem diseases or moral matters, what are the symptoms, how do you motivate the ill professional to seek help? Panel/Question and Answer Period: Russell F. Smith, MD; Carl A. Gagliardi, MD, Dearborn; Joyce W. Mason, MD, Ann Arbor; Stephen C. Mason, MD, Ann Arbor; Robert Niccolini, MD, Detroit, and Ward M. Smathers, MD, Detroit.

Saturday, October 15 (contd.)

6:30 p.m.	Dinner
8 p.m.	"Have I Got a Problem for You: A Cracker Barrel Session" Doctors Smith, Gagliardi, J. Mason, S. Mason, Niccolini, and Smathers Update on MSMS and MAOPS activities, programs, and services for the well-being of physicians, followed by cracker barrel discussion and problem/information sharing.
10 p.m.	International Doctors in Alcoholics Anonymous Demonstration Meeting

Sunday, October 16

8 a.m.	Breakfast
10 a.m.	"Re-Entry Problems" Doctors Smith, Gagliardi, J. Mason, S. Mason, Niccolini, and Smathers Problems with regulatory agencies, hospitals, and other institutions will be discussed. Can we as a profession accept and treat stigmatized illness in physicians as a real disease? Can we really do what we say we can?
Noon	Luncheon (optional)
	Conference Ends

For additional information, contact Katie Brewbaker, Michigan State Medical Society, Box 950, East Lansing, MI 48823; (517) 337-1351.

To register for conference, please complete the following form:

1st ANNUAL MICHIGAN CONFERENCE ON WELL-BEING OF PHYSICIANS

Friday-Saturday-Sunday, October 14-15-16, 1983
Sugar Loaf Conference Center, Cedar

ADVANCE REGISTRATION FORM

Please complete and mail to Michigan State Medical Society, Box 950, East Lansing 48823

Registration Fee $75 per person for those attending conference sessions.

(No fee for residents or students attending sessions; no fee for guests not attending sessions).

REGISTRANT(S) *(List names & check category)*	CONFEREE $75	RESIDENT Comp.	STUDENT Comp.	GUEST Comp.
____________	______	______	______	______
____________	______	______	______	______
____________	______	______	______	______
____________	______	______	______	______
AMOUNT DUE	$______	-0-	-0-	-0-

Mail confirmation to *(name, address, zip)* ________________________________

____

(Please make check payable to Michigan State Medical Society)

Please see housing form next page

For room reservations at Sugar Loaf for the Michigan Conference on Well-Being of Physicians, please complete the reservation form below.

RESERVATION DEADLINE: Friday, September 16, 1983. After this date, reservations will be made on availability basis.

DEPOSIT: $25 per room deposit required in advance to confirm reservation. Cancellations or changes must be received in writing seven days prior to arrival. After seven days, deposits are non-refundable.

RATES: $86.75 plus tax, per person, per package, based on double occupancy; $126.75 plus tax, per person, per package, based on single occupancy; Children 18 and under sleep free in parents' room. Meals are separate.

Housing Reservation Form
1983 MSMS Conference on the Well-Being of Physicians

Sugar Loaf, Cedar **October 14-15-16, 1983**

Name: ______________________

City/State/ZIP: ______________________

Arrival Date: ______________________

Departure Date: ______________________

Rooming with: ______________________

____

____

Address: ______________________

Phone: ____________ No. in Party: ________

Accommodations: (Please Check One)

Single Occupancy: ______________________

Double Occupancy: ______________________

Detach & return with deposit to: Sugar Loaf Resort, Route #1, Cedar, MI 49621

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Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

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You're invited to MSMS Annual Scientific Meeting

MSMS invites you to attend its 1983 Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn! As the headline above emphasizes, you are the most important part of this entire continuing medical education event.

This year's meeting theme, "MSMS puts you in touch with high tech," also emphasizes the MSMS member. And the committee and I have had you in mind throughout the past year of planning.

We have relied heavily on your recommendations from previous meetings and your requests for future discussions. With the help of your evaluation forms and the suggestions of your esteemed colleagues in medical education, hospitals and specialty societies, we have put together the best program for generalist and specialist.

The three-day event will present 55 half-day courses which are fully described in this newsletter. On page 19 of this issue is the registration form, which you are invited to fill out and mail to MSMS headquarters, along with your registration fees.

With our theme of putting you in touch, we have planned the following new courses demonstrating the most useful, economical management of technologies in medical care diagnosis and treatment:

Flow Cytometry
Hyperbaric Oxygen Therapy
Gastrointestinal Scintigraphy
Medical Use of Lasers
Vision
Diagnostic and Therapeutic
  Interventional Radiology
Unique Techniques in Plastic
  Surgery

Each course awards three Category I credit hours and is presented by a specialty society, MSMS section, or department of one of the state's three medical schools. Physicians attending the entire three-day meeting may earn a total of 18 Category I credit hours.

Special events planned in conjunction with the three-day meeting include two new seminars on physicians' personal investment alternatives and on the impact of TEFRA on retirement plans. The non-credit seminars will be staged from 8 to 10 p.m. Monday, Nov. 14 and Tuesday, Nov. 15, in the hotel. They will be presented by the MSMS Physician Service Group and the E.F. Hutton Company. The fee will be $10 per physician, with guests welcome free of charge.

Other special events include the luncheon meeting of the Michigan Psychiatric Society Women's Issues Committee, and receptions and dinners for the Michigan Society of General Surgeons, Michigan Ophthalmological Society, Michigan Society of Colon and Rectal Surgeons, Michigan Otolaryngological Society and Michigan Branch, American Urological Association. Again, the annual reception is planned for the Wayne State University Medical Alumni. See page 13 for an at-a-glance schedule of special events.

Doctor Rovner

Sixty-five companies and organizations eager to display the newest medical products and services have reserved space in the giant MSMS Exhibition Hall. The hall will be open each day for physicians' visits before, during and after classes.

More exhibit information appears on the back page of this issue.

Once again, MSMS invites you to earn Category I CME credit while you learn with your colleagues about the latest developments and techniques of medicine. Read the descriptions of the many and varied courses summarized on these pages, check the courses of your choice on the registration form and return with your money to MSMS today.

See you at the Meeting!

David R. Rovner

Tuesday morning, Nov. 15

All courses run from 8:30 to noon with half-hour break

■ Basic Cardiac Life Support

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is being offered for those physicians who are not currently certified in Basic Life Support and who may wish to become certified. It will consist of basic lectures, including management of the airway and cardiac massage. Time will be provided for a practice session on the manikins, but prior CPR practice is highly recommended.

COURSE DIRECTOR: Robert K. Orr, DO, Lansing

PRESIDING: Doctor Orr

FACULTY:

Robert K. Orr, DO, Director, Emergency Medical Services, Lansing General Hospital; **Paul Berlin, A-EMT,** Midland Hospital; **Michael Gurecki, A-EMT,** Lansing Fire Department; **Jane Hedges, RN,** Lansing General Hospital; **Valorie Kinne,** BCLS Instructor, Lansing General Hospital; **Jack Lynch, A-EMT,** Meridian Township Fire Department; **Mary Ellen McCloy, RN,** Lansing General Hospital.

■ Cancer Patient Management in the 1980s: The Role of Radiation Oncology

PRESENTED BY: Michigan Society of Therapeutic Radiologists

This program will present the role of radiation therapy in the management of malignant neoplasms in the 1980s as a curative and palliative therapeutic modality with emphasis on improvements over the past two decades. The program considers radiation oncology in the continuum of care of patients with cancer, emphasizing the need for early consultation and consideration of radiation therapy in the initial and continued care of patients. We will present data on national and regional experience in regard to the utilization of facilities and personnel available for the delivery of radiation therapy. Prospects for the future will be summarized including the possible benefits of the use of newer modalities, such as particle therapy (neutrons), radiation sensitizers, and monoclonal antibodies, etc. Presentations will describe the improved role of radiation therapy in cure of cancers of several sites, such as prostate, cervix and uterus, head and neck, breast and lung.

COURSE DIRECTOR: Harold Perry, MD, Detroit

PRESIDING: Doctor Perry

SPEAKERS/SUBJECTS:

William E. Powers, MD, Professor and Chairman, Department of Radiation Oncology, Wayne State University School of Medicine; Chairman, Radiation Oncology Center, Harper Hospital, Detroit

"The Place of Radiation Therapy in the Management of Malignancies"

Harold Perry, MD, Clinical Professor, Department of Radiation Oncology, Wayne State University School of Medicine; Chairman, Department of Radiation Therapy, Sinai Hospital of Detroit

"Radiation Treatment of Cancer of the Prostate"

Doctor Powers

"Primary Radiation Therapy for Carcinoma of the Breast"

Chiu-Chen Wang, MD, Professor, Department of Radiation Therapy, Harvard Medical School; Head, Division of Clinical Services, Department of Radiation Medicine, Massachusetts General Hospital, Boston, Massachusetts

"Radiation Therapy of Head and Neck Tumors: Update 1983"

Jeannie J. Kinzie, MD, Associate Professor, Department of Radiation Oncology, Wayne State University School of Medicine; Vice-Chief, Radiation Oncology Center, Harper Hospital, Detroit

"Lymphoma: The Role of Radiation Therapy"

H. Gunter Seydel, MD, Clinical Professor, Department of Radiation Oncology, Wayne State University School of Medicine; Chairman, Department of Therapeutic Radiology, Henry Ford Hospital, Detroit

"The Place of Radiation Therapy in the Treatment of Inoperable Lung Cancer"

■ Child Abuse: How to Make the System Work for Your Patient

PRESENTED BY: MSMS Committee on Child Abuse/Neglect

This course will provide a "multidisciplinary" approach to handling suspected cases of child abuse and neglect, with representatives from the police, protective services, and the legal system on hand to help physicians "use the system" in order to meet the medical, emotional, and legal needs of the child. The course will include: (1) a review of history and physical exam clues to the diagnosis of child abuse; (2) legal guidance on testifying in court on child abuse cases; (3) information on assistance that can be provided by law enforcement and protective services officials; (4) tips on how to set up or utilize existing SCAN (Suspected Child Abuse and Neglect) teams and community councils.

COURSE CO–DIRECTORS: Brooker L. Masters, MD, Chairman, MSMS Committee on Child Abuse/Neglect; Fremont and **Barbara Meyer Lucas, MD,** Detroit

PRESIDING: Doctor Masters

SPEAKERS/SUBJECTS:

Barbara Meyer Lucas, MD, Director, Child Abuse and Neglect Prevention Program, Department of Pediatrics, Mount Carmel Mercy Hospital, Detroit

"The Physician's Role in Child Abuse Detection and Prevention"

(Speaker to be Announced), Community Services Section, Michigan Department of State Police

"Interacting with Police in Suspected Child Abuse and Neglect Cases"

Shirley Tate, Director, Office of Children and Youth Services, Lansing

"Interacting with Protective Services in Suspected Child Abuse and Neglect Cases"

Christina Vadino, JD, Juvenile Defenders Office, Detroit

"Interacting with the Legal System in Suspected Child Abuse and Neglect Cases"

Sharon Shay, Executive Director, Council for the Prevention of Child Abuse and Neglect

"The Role of Community Teams in Child Abuse Detection and Prevention"

■ Diabetes — Current Management and New Developments

PRESENTED BY: Division of Metabolic Diseases, Henry Ford Hospital

This course will review the application of the advances and developments in the treatment of diabetes mellitus that provide the means to proceed with a study such as the Diabetes Control and Complications Trial. The importance of good control during pregnancy and the means to accomplish it will be discussed. Indications for the treatment of diabetes with human insulin along with guidelines for its use will be presented.

COURSE DIRECTOR: Dorothy M. Kahkonen, MD, Detroit

PRESIDING: Doctor Kahkonen

SPEAKERS/SUBJECTS:

Fred W. Whitehouse, MD, Head, Division of Metabolic Diseases, Henry Ford Hospital, Detroit

"Diabetes Control and Complications Trial: Background and Rationale"

Davida F. Kruger, MSN, Clinical Nurse Specialist, Division of Metabolic Diseases, Henry Ford Hospital, Detroit

"Diabetes Control and Complications Trial: Implementation"

J. David Fachnie, MD, Staff Physician, Division of Metabolic Diseases, Henry Ford Hospital, Detroit

"Diabetes and Pregnancy"

Dorothy M. Kahkonen, MD, Staff Physician, Division of Metabolic Diseases, Henry Ford Hospital, Detroit

"Human Insulin: Indications and Guidelines"

■ Emergency Psychiatry for the Non-Psychiatrist

PRESENTED BY: Michigan Psychiatric Society

This course focuses on the kinds of psychiatric emergencies that can present in the general medical or emergency department setting. The participant will be exposed to concepts of stabilizing and making an initial determination of the needs of a psychiatric patient, including the patient with an acute grief reaction, the suicidal patient, the violent patient, and the psychotic or confused patient who may have an organic brain disorder. Videotaped vignettes will be used to facilitate discussion of these types of problems.

COURSE DIRECTOR: Beverly Fauman, MD, Detroit

PRESIDING: Doctor Fauman

SPEAKERS:

Beverly J. Fauman, MD, Director of Education, Department of Psychiatry, Sinai Hospital of Detroit; Assistant Professor, Department of Psychiatry, Wayne State University School of Medicine

Gail M. Barton, MD, MPH, Medical Director, Howard Mental Health Services, Burlington, Vermont; Associate Clinical Professor, Department of Psychiatry, University of Vermont

■ Evaluation and Management of Infertile Couples

PRESENTED BY: Wayne State University-Hutzel Hospital and C.S. Mott Center for Human Growth and Development

The objective of this course is to present a succinct overview of the evaluation and management of infertile couples. Approximately 10 to 15 percent of all couples experience infertility and seek help from physicians. This course should provide the average physician with a good working knowledge for the office evaluation of infertility and familiarize him/her with the new techniques available for the management of childlessness.

COURSE DIRECTOR: Kamran S. Moghissi, MD, Detroit

PRESIDING: Doctor Moghissi

SPEAKERS/SUBJECTS:

Kamran S. Moghissi, MD, Professor, Department of Obstetrics/Gynecology, Director, Division of Reproductive Endocrinology and Infertility, WSU–Hutzel Hospital and C.S. Mott Center for Human Growth and Development, Detroit

"Workup of Infertile Couples Including History, Physical Examination and Special Diagnostic Methods"

Anthony J. Thomas, Jr., MD, Head, Section of Male Infertility, Department of Urology, Cleveland Clinic Foundation, Cleveland

"Evaluation of Male Partner of Infertile Unit"

David M. Magyar, DO, Assistant Professor, Department of Obstetrics/Gynecology, WSU-Hutzel Hospital and C.S. Mott Center for Human Growth and Development, Detroit

"Diagnosis and Management of Tubal and Peritoneal Disorders in Infertility such as Microsurgery Laser, In Vitro Fertilization, and Embryo Transfer"

Maria F. Hayes, MD, Assistant Professor, Department of Obstetrics/Gynecology, WSU-Hutzel Hospital and C.S. Mott Center for Human Growth and Development, Detroit

"Diagnosis and Management of Ovulatory Disorders and Therapeutic Role of Clomiphene Citrate, Human Menopausal Gonadotropin, Human Chorionic Gonadotropin and Bromocriptine"

■ Flow Cytometry: Clinical Application

PRESENTED BY: Department of Pathology, University of Michigan Medical School

The aim of this course will be to introduce physicians to the new technology of flow cytometry (FCM) and its application to clinical diagnoses. Following an introductory lecture on FCM, case presentations will be used to illustrate the use of monoclonal antibodies and FCM in immunologically phenotyping cases of leukemia and lymphoma. The prognostic significance of immunomorphologic diagnoses will be discussed and the role of FCM in renal transplantation, congenital and acquired immunodeficiency disorders will be described. This will be followed by a brief discussion of its application in cytopathology and the future application of FCM to the diagnosis of solid tumors.

COURSE DIRECTOR: Bertram Schnitzer, MD, Ann Arbor

PRESIDING: Kenneth D. McClatchey, MD, DDS, Associate Professor and Associate Chairman, Department of Pathology; Associate Director, Clinical Pathology Laboratories; Assistant Professor, Oral Pathology, University of Michigan Medical School and School of Dentistry

SPEAKERS/SUBJECTS:

Edmund J. Lovett, III, PhD, Assistant Professor, Department of Pathology, University of Michigan Medical School

"Basic Concepts and Clinical Application of Flow Cytometry"

Bertram Schnitzer, MD, Professor, Department of Pathology, University of Michigan Medical School

"Application of Flow Cytometry in the Diagnosis of Leukemias and Lymphomas"

David F. Keren, MD, Associate Professor, Department of Pathology, University of Michigan Medical School

"Flow Cytometry in Immunodeficiency Disease and Renal Transplantation"

Andrew Flint, MD, Assistant Professor, Department of Pathology, University of Michigan Medical School

"The Applications of Flow Cytometry to Diagnostic Cytology"

PANEL PRESENTATION:

"Future Application of Flow Cytometry"

Doctors Flint, Keren, Lovett and **Schnitzer**

■ Helping the Troubled Employee: The Role of Physicians and Industry

PRESENTED BY: Michigan Occupational Medical Association

This course through didactic presentations, case presentations and small group discussion will provide primary physicians with specific information regarding employee assistance programs in existence within business and industry. The course will introduce information and technology important to the physician to increase his/her efficacy in intervening with patients who also happen to be employed in a company having an existing employee assistance program. Upon completion of this course, the physician should know the basic characteristics of an employee assistance program, the benefits of an employee assistance program and the methodology necessary to effectively work in cooperative manner with employers regarding treatment of an employee.

COURSE DIRECTOR: Jack E. Benkert, MD, Medical Director, General Motors Truck and Bus Division, Flint

PRESIDING: Doctor Benkert

SPEAKERS/SUBJECTS:

Gary L. Hankinson, Program Director, Insight Addiction Studies Program, Hurley Hospital, Flint

"The Employee Assistance Program Concept: How Does It Work?"

Daniel Lanier, DSW, Assistant Program Director, Substance Abuse Programs, Detroit

"The Benefits of an Employee Assistance Program from the Employer's Perspective"

■ Medically-Related Communication Impairments: The Physician's Role

PRESENTED BY: Speech and Language Pathology Department, William Beaumont Hospital, Royal Oak

This course will present the various medically related speech, language and voice disorders commonly encountered by practicing physicians. Through lecture, tape recordings and demonstration the audience will be presented with information that will enhance identification, assessment and referral considerations. The course will cover both pediatric and adult problems and present handouts concerning developmental norms, family counseling and available literature for office use. Treatment techniques used by speech-language pathologists will be outlined and the latest uses of computer treatment will be presented.

COURSE CO-DIRECTORS: Michael I. Rolnick, PhD, Royal Oak and **Myron M. LaBan, MD,** Royal Oak

PRESIDING: Doctor Rolnick

SPEAKERS/SUBJECTS:

Myron M. LaBan, MD, Chairman, Physical Medicine and Rehabilitation Services, William Beaumont Hospital; Clinical Associate Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine

"Communication Disorders and the Physician"

Michael I. Rolnick, PhD, Director, Speech and Language Pathology Department, William Beaumont Hospital, Royal Oak

"Phonatory Disorders and Voice Analysis"

Carole Goff, MA, Coordinator, Children's Services, Center for Childhood Aphasia and Apraxia, Speech and Language Pathology Department, William Beaumont Hospital, Royal Oak

"Differential Diagnosis of Pediatric Speech and Language Disorders: Implications for Referral"

Candace Gordon, MA, Coordinator, Rehabilitation Unit-Speech Service, Speech and Language Pathology Department, William Beaumont Hospital, Royal Oak

"Aphasia Rehabilitation and Cognitive Retraining for Brain Damaged Patients"

Robert G. Johnston, PhD, Head, Communication Disorders and Sciences, Wayne State University School of Medicine

"Treating Families of the Communicatively Impaired: Basic Counseling Concepts for the Physician"

■ Traumatic Injuries to the Head, Spine and Peripheral Nerves

PRESENTED BY: Department of Neurosurgery, Wayne State University School of Medicine

Traumatic injury to the nervous system constitutes one of the major causes of disability in the United States. In a single course, participants will review and gain expertise in the diagnosis and treatment of head, spinal and peripheral nerve injuries.

COURSE DIRECTOR: Robert E.M. Ho, MD, Troy

PRESIDING: Doctor Ho

SPEAKERS/SUBJECTS:

John Gilroy, MD, Professor and Chairman, Department of Neurology, Wayne State University School of Medicine

"Common Peripheral Nerve Injuries"

L. Murray Thomas, MD, Professor and Chairman, Department of Neurosurgery, Wayne State University School of Medicine

"Acute Spinal Injury: A Practical Approach to Diagnosis and Management"

Mary Ann Guidice, MD, Assistant Professor, Department of Neurology, Wayne State University School of Medicine

"Head Injury: Intermediate and Long Term Management"

Robert E.M. Ho, MD, Assistant Professor, Department of Neurosurgery, Wayne State University School of Medicine

"Preservation of Brain Function In Acute Head Injury"

Complete and return registration form on page 19

Tuesday afternoon, Nov. 15

All courses run from 1:30 to 5 p.m. with half-hour break

■ Adding Life to Years: Meeting the Needs of the Aged

PRESENTED BY: MSMS Committee on Aging and the Michigan Health Council

The course will give participants an overview of the medical, social, and psychological needs of the aged patient. Emphasis will be placed on the physician skills necessary in managing the aging patient, the appropriate utilization of existing community services, the epidemiology of the aged, geriatric depression and Alzheimer's Disease.

COURSE DIRECTOR: William T. Bateman, MD, Chairman, MSMS Committee on Aging; Medical Director, Upjohn Community Nursing Home, Kalamazoo

PRESIDING: Doctor Bateman

SPEAKERS/SUBJECTS:

Richard H. Wakulat, MD, Departments of Internal Medicine and Geriatrics, Burns Clinic Medical Center, Petoskey
"Management of the Aging Patient"

James G. O'Brien, MD, Associate Professor, Department of Family Practice, Michigan State University College of Human Medicine
"The Role of the Community and Physician in the Care of Alzheimer's Disease"

Ruth B. Hoppe, MD, Associate Professor, Department of Medicine, Michigan State University College of Human Medicine
"Epidemiology of the Aging"

James Paauw, MD, Clinical Nutrition Research Fellow, Butterworth Hospital, Grand Rapids; Resident Instructor, Department of Surgery, Michigan State University College of Human Medicine
"Nutritional Considerations and the Elderly Patient"

Sumer Verma, MD, Associate Professor, Departments of Psychiatry and Medicine, Michigan State University College of Human Medicine; Visiting Professor, Cambridge University, England
"Geriatric Depression"

■ An Overview of the Human Health Effects of Nuclear Weapons

PRESENTED BY: Physicians for Social Responsibility

This course will present a thorough, factual examination of the acute, chronic and long-term effects of a full-scale attack on populated areas using nuclear fission weapons. Blast, thermal and radiation injuries will be delineated together with the proposed defenses against acute injury, carcinogenesis, mutagenesis and teratogenesis will be discussed, together with Doctor Neel's thirty-five year research efforts on the effects of the Hiroshima and Nagasaki bombs.

COURSE DIRECTOR: Eugene V.D. Perrin, MD, Detroit

PRESIDING: Doctor Perrin

SPEAKERS/SUBJECTS:

Eugene V.D. Perrin, MD, Professor, Department of Pathology and Associate Professor, Department of Pediatrics, Wayne State University School of Medicine; Director, Department of Histopathology, Children's Hospital of Michigan, Detroit
"Acute Effects of Nuclear War on Human Populations and Ecosystems"

Arthur J. Vander, MD, Professor, Department of Physiology, University of Michigan Medical School
"Medical Problems of the Post-Attack Period"

James V. Neel, MD, Lee R. Dice Distinguished University Professor, Department of Human Genetics; Professor, Department of Internal Medicine, University of Michigan Medical School
"The Immediate and Delayed Effects of the Atomic Bombings of Hiroshima and Nagasaki"

■ Chronic Drug Therapy and the Surgical Patient

PRESENTED BY: Michigan Society of Anesthesiologists and Department of Anesthesiology, Wayne State University School of Medicine

This course will provide practical information on the proper perioperative management of the more common medications that patients have been taking when they come to surgery. Five, twenty-minute lectures will cover: Calcium blockers, beta blockers, antihypertensives, diabetic drugs, and psychotherapeutic drugs. A panel discussion then will cover any other medications that are of interest to the audience. Upon completion of the course, the attendee should know which drugs should be either discontinued, maintained or increased.

COURSE DIRECTOR: Gaylord D. Alexander, MD, Detroit

PRESIDING: Doctor Alexander

SPEAKERS/SUBJECTS:

Gaylord D. Alexander, MD, Associate Professor, Department of Anesthesiology, Wayne State University School of Medicine
"Psychotherapeutic Agents"

Morris Brown, MD, Medical Director of Critical Care, Department of Anesthesiology, Sinai Hospital of Detroit
"Antihypertensives"

John Everett, MD, Anesthesiologist, Edward W. Sparrow Hospital, Lansing
"Diabetic Drugs"

Glenn A. Rosin, MD, Department of Anesthesiology, William Beaumont Hospital, Royal Oak
"Calcium Blockers"

Jeffrey P. Serwin, DO, Department of Anesthesiology, Henry Ford Hospital, Detroit
"Beta Blockers"

Diagnosis and Management of Pelvic Pain

PRESENTED BY: Department of Obstetrics and Gynecology, University of Michigan Medical School and Michigan Section, American College of Obstetricians and Gynecologists

Pelvic pain, acute or chronic, presents diagnostic and therapeutic dilemmas to general practitioners, internists, surgeons and gynecologists. This course will emphasize chronic pelvic pain and describe newer strategies for management. The pros and cons of hysterectomy will also be addressed. The presentations will be followed by open forum and biofeedback equipment will be available for demonstration at the end of the session.

COURSE DIRECTOR: John J. LaFerla, MD, Ann Arbor

PRESIDING: Doctor LaFerla

SPEAKERS/SUBJECTS:

Jonathan W.T. Ayres, MD, Assistant Professor and Director of Gynecologic Endocrinology, Department of Obstetrics and Gynecology, University of Michigan Medical School
"Management of Pelvic Pain Due to Endometriosis and/or Adhesions"
George W. Morley, MD, Professor and Director of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of Michigan Medical School
"Hysterectomy for Pelvic Pain"
"Pain Management in Patients with Gynecologic Malignancy"
John J. LaFerla, MD, Associate Professor and Director of Behavioral Obstetrics/Gynecology, Department of Obstetrics and Gynecology, University of Michigan Medical School
"New Approaches to Chronic Pelvic Pain"
Patricia Blackmer, Clinical Coordinator, Behavioral Medicine, Department of Psychiatry, University of Michigan Medical School
"Demonstration of Biofeedback"

High Quality Care With DRGs

PRESENTED BY: MSMS Planning Committee for Annual Scientific Meeting

This course is designed to acquaint practicing physicians with diagnosis related groups (DRGs), a new development in the area of health care cost containment efforts by the health care financing administration and how they may provide high quality medical care to their patients in spite of them. The mechanism of DRGs will be to set prices for diagnoses rather than length of stay and procedures performed. The uniform pricing structure will begin its phase-in on October 1, 1983. Although the primary effect is upon hospital reimbursement, high quality care for our patients requires increasing awareness of cost containment and new methods for attaining the most effective plan of management and therapy which is at the same time cost effective. We will present an overview of "clinical decision and analysis" together with some practical illustrations taken from the field of primary care. We believe that decision analytic techniques can be utilized to design the most cost effective program for each individual patient.

COURSE DIRECTOR: David R. Rovner, MD, East Lansing

PRESIDING: Doctor Rovner

SPEAKERS/SUBJECTS:

Samuel M. McMahon, MD, Vice President for Medical Affairs, Ingham Medical Center, Lansing
"DRGs: What They Are, What They Are Supposed to do and Policy Questions Inherent in Their Use"
Arthur S. Elstein, PhD, Professor, Department of Medical Education, Research and Development, Michigan State University College of Human Medicine
"Overview of Clinical Decision Analysis"
David R. Rovner, MD, Professor, Department of Medicine; Chief, Department of Endocrinology and Metabolism, Michigan State University College of Human Medicine
"Application of Clinical Decision Analysis to Specific Patient Problems in Primary Care"

Medical Genetics for the Practicing Physician

PRESENTED BY: Departments of Internal Medicine, Human Genetics and Pediatrics, University of Michigan Medical School

This course, through case presentations, will instruct primary and consulting physicians in the application of simple genetic principles to the diagnosis, management and prevention of illness. Indications for consultation and referral will be discussed, as well as newer techniques of prenatal diagnosis. The role of genetic counseling in the prevention of disease and management of families will be emphasized. Half of the time will be reserved for questions and discussion of participants' own cases.

COURSE DIRECTOR: Thomas D. Gelehrter, MD, Ann Arbor

PRESIDING: Doctor Gelehrter

SPEAKERS:

Thomas D. Gelehrter, MD, Professor, Departments of Internal Medicine and Human Genetics; Director, Division of Medical Genetics, University of Michigan Medical School
Golder N. Wilson, MD, PhD, Associate Professor, Departments of Pediatrics and Communicable Diseases, University of Michigan Medical School

Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal

PRESENTED BY: MSMS Program to Assist Impaired Physicians

The practicing physician, regardless of specialty, encounters more chemically dependent patients. This results from better diagnostic skills, less social stigma, and involvement of a broader age group. Case finding has, in general, exceeded our clinical skills. Few physicians receive adequate training in the management of the acute neurological or sexual dysfunctions associated with sedative hypnotic addiction. This course through lectures and dialogue, intends to prepare the practicing physician to approach these problems with greater skill and confidence.

COURSE DIRECTOR: Russell F. Smith, MD, Brighton

PRESIDING: Doctor Smith

SPEAKERS/SUBJECTS:

Russell F. Smith, MD, Medical Director, Brighton Hospital and Guest House Sanitarium, Brighton
"The New Alcoholism — Cardiac vs. Gastroenterological Disease"
Richard A. Morin, MD, Medical Director, Eastwood Clinics, Metropolitan Detroit; Psychiatric Consultant, Monarch Clinic, Detroit; Clinical Instructor, Wayne State University School of Medicine
"Management of Alcohol and Drug Related Sexual Dysfunction"

Doctor Smith
"Medical Management of Acute Alcohol Withdrawal and Complications"

Pediatric Immunology/Infectious Diseases: New Concepts and Treatment Modalities

PRESENTED BY: Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

The aim of this course will be to introduce and discuss recent advances in diagnosis and treatment within the areas of pediatric immunology and infectious diseases. Specifically immunotherapy for immunodeficiency syndromes, recognition of infant AIDS, pediatric indications for the newer cephalosporin antibiotics, and antiviral chemotherapy will be covered. Provision of practical information is to be stressed, and indications for consultation and referral outlined. A portion of time will be reserved for questions and discussion of participants' own cases.

COURSE DIRECTOR: Dennis L. Murray, MD, East Lansing

PRESIDING: Doctor Murray

SPEAKERS/SUBJECTS:

Donald B. Kaufman, MD, Professor, Department of Pediatrics and Human Development and Director, Clinical Immunology Laboratory, Michigan State University College of Human Medicine
"Congenital Immunodeficiency and Infant AIDS: Are They Different?"

Ralph Gordon, MD, Professor, Department of Pediatrics and Human Development and Acting Assistant Dean, Michigan State University College of Human Medicine, Saginaw Campus
"Pediatric Indications for the Newer Cephalosporin Antibiotics"
"Rifampin Prophylaxis for Haemophilus influenzal *type b Infections"*

Dennis L. Murray, MD, Assistant Professor, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine
"Newer Concepts in Rapid Viral Diagnosis and Antiviral Chemotherapy"

Some Burning Issues in Gastroenterology

PRESENTED BY: Department of Medicine, Michigan State University College of Human Medicine

This course will provide primary physicians with an update on diagnosis and management of duodenal and gastric ulcer disease, as well as an approach to the common and poorly-understood problem of x-ray negative dyspepsia. Material will be presented in short lecture and case presentation format; panel discussion with audience participation will follow. At the conclusion, participants will have improved competence in expeditiously diagnosing and treating patients with acid peptic symptoms.

COURSE DIRECTOR: David S. Greenbaum, MD, East Lansing

PRESIDING: Doctor Greenbaum

SPEAKERS:

Howard A. Dean, DO, Associate Professor, Department of Medicine, Michigan State University College of Osteopathic Medicine

David S. Greenbaum, MD, Professor, Department of Medicine, Michigan State University College of Human Medicine

James M. Harkema, MD, Associate Professor, Department of Surgery, Michigan State University College of Human Medicine

James E. Mayle, MD, Assistant Professor, Department of Medicine, Michigan State University College of Human Medicine

Your 55 courses offer 3 hours each of Category I credit

Wednesday morning, Nov. 16

All courses run from 8:30 to noon with half-hour break

■ A Comprehensive Review of Anorexia Nervosa

PRESENTED BY: Department of Psychiatry, Harper-Grace Hospitals, Wayne State University School of Medicine

The course will review the signs and symptoms of anorexia nervosa and bulimia. The natural history of these disorders will be described as well as the associated psychopathology. Speakers will review CNS mechanisms for the control of appetite and some interesting findings relative to the biochemistry of anorexia and bulimia, as well as techniques for nutritional assessment of the patient, how the need for parenteral nutrition is determined and how nutritional repletion is achieved. Other areas for discussion include the families of the anorexic and bulimic patients and the nature of the interactions between family and patient. Video-cassettes will illustrate some therapeutic approaches to altering family patterns which seem to drive these disorders.

COURSE DIRECTOR: Elliot D. Luby, MD, Detroit

PRESIDING: Doctor Luby

SPEAKERS/SUBJECTS:

Elliot D. Luby, MD, Chief, Department of Psychiatry, Harper Hospital, Detroit; Professor of Psychiatry and Law, Wayne State University Schools of Medicine and Law
"The Clinical Course of Anorexia Nervosa"

Mary Ann Marrazzi, PhD, Associate Professor, Department of Pharmacology, Wayne State University School of Medicine
"Neurophysiologic Control of Appetite"

Joseph Kinzie, MD, Nutritional Oncologist, Department of Medicine, Harper Hospital, Detroit
"Nutritional Management of Anorexia Nervosa"

David Wesner, ACSW, Psychiatric Social Work Supervisor, Department of Social Work, Harper Hospital, Detroit
"Family Treatment of Anorexia Nervosa"

Kenneth Pitts, MD, Detroit, Orchard Hills Clinic, Farmington Hills
"Long Term Management of Anorexia Nervosa"

■ Arm Pain and Dysfunction: Diagnosis and Management

PRESENTED BY: Departments of Rehabilitation Medicine and Internal Medicine, Sinai Hospital of Detroit

This course, through actual patient presentation and demonstration using video camera enhancement, multidisciplinary panel reaction and discussion, will review and demonstrate the diagnosis, mechanics and treatment of some of the causes of arm pain and dysfunction. Diseases of the cervical spine, thoracic outlet, ligament and tendon, will be discussed along with periarticular shoulder problems. Problems of nerve entrapment and rheumatic disease will be presented. Upon completion of the course, physicians involved in primary care of adult patients should understand some of the techniques of physical examination of the upper extremity, be able to diagnose some problems which cause arm dysfunction, have some understanding of the mechanics and treatment of these problems and also be aware of the use of electrodiagnostic testing in helping to evaluate and diagnose arm pain and dysfunction.

COURSE DIRECTOR: Joseph C. Honet, MD, Detroit

PRESIDING: Doctor Honet

SPEAKERS/SUBJECTS:

Joseph C. Honet, MD, Chairman, Department of Rehabilitation Medicine, Sinai Hospital of Detroit; Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine
"Physical Examination of the Upper Extremity and Nerve Entrapment as a Cause of Arm Pain and Dysfunction"

Samuel Indenbaum, MD, Chief, Section of Rheumatology, Department of Internal Medicine, Sinai Hospital of Detroit; Clinical Associate Professor, Department of Internal Medicine, Wayne State University School of Medicine
"Physical Examination of the Upper Extremity and Rheumatological Causes of Arm Pain"

William M. Leuchter, MD, Chief, Section of Neurology, Department of Internal Medicine, Sinai Hospital of Detroit
"Physical Examination of the Upper Extremity and Cervical Spine and Thoracic Outlet Diseases as a Cause of Arm Pain"

Maury R. Ellenberg, MD, Associate Attending Physician, Department of Rehabilitation Medicine, Sinai Hospital of Detroit; Clinical Instructor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine
"Electrodiagnosis in the Evaluation of Arm Pain and Periarticular Shoulder Problems as a Cause of Arm Pain"

■ Basic Cardiac Life Support

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is being offered for those physicians who are not currently certified in Basic Life Support and who may wish to become certified. It will consist of basic lectures, including management of the airway and cardiac massage. Time will be provided for a practice session on the manikins, but prior CPR practice is highly recommended.

COURSE DIRECTOR: Robert K. Orr, DO, Lansing

PRESIDING: Doctor Orr

FACULTY:

Robert K. Orr, DO, Director, Emergency Medical Services, Lansing General Hospital; **Paul Berlin, A-EMT,** Midland Hospital; **Michael Gurecki, A-EMT,** Lansing Fire Department; **Jane Hedges, RN,** Lansing General Hospital; **Valorie Kinne,** BCLS Instructor, Lansing General Hospital; **Jack Lynch, A-EMT,** Meridian Township Fire Department; **Mary Ellen McCloy, RN,** Lansing General Hospital

■ Esophageal Disorders for the General Physician

PRESENTED BY: Michigan Society of Thoracic Surgeons

This course is designed to provide the primary and consulting physician with a review of major esophageal problems including neoplasia, reflux esophagitis, hiatus hernia, and functional and motor disorders of swallowing. A panel of authorities will stress recognition, diagnosis, and will discuss methods of treatment, conservative and surgical. Following presentations, the panel will conduct a forum to discuss questions and review clinical problems presented by the audience.

COURSE DIRECTOR: Joe D. Morris, MD, Clinical Professor, Department of Thoracic Surgery, University of Michigan Medical School

PRESIDING: Doctor Morris

SPEAKERS:

Murray Ehrenpreis, MD, Associate Professor, Department of Medicine, Division of Gastroenterology, Wayne State University School of Medicine
Mark B. Orringer, MD, Professor, Department of Thoracic Surgery, University of Michigan Medical School
Zwi Steiger, MD, Professor, Department of Thoracic Surgery, Wayne State University School of Medicine

■ Evaluation and Treatment of the Dizzy Patient

PRESENTED BY: Department of Otolaryngology, Wayne State University School of Medicine

This course is designed to present the practitioner with a rational scheme for working up and managing the dizzy patient. Emphasis will be placed on history taking, the differential separation of non-vestibular disease and straight forward laboratory methodology. Discussion of management will be facilitated by a panel discussion of select representative cases, with audience questions and participation encouraged.

COURSE DIRECTOR: Sean B. Peppard, MD, Detroit

PRESIDING: Doctor Peppard

SPEAKERS/SUBJECTS:

Robert H. Mathog, MD, Professor and Chairman, Department of Otolaryngology, Wayne State University School of Medicine
"Obtaining a Pertinent History"
Sean B. Peppard, MD, Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine
"The Differential Diagnosis of Vertigo"
William F. Rintelmann, PhD, Professor and Chairman, Department of Audiology, Wayne State University School of Medicine
"The Work-Up: Audiologic Tests"
Erik W. Nielsen, MD, Instructor, Department of Otolaryngology, Wayne State University School of Medicine
"The Work-Up: Vestibular Tests"
Doctor Nielsen
"Medical and Surgical Management"

PANEL PRESENTATION:
Doctors **Mathog, Nielsen, Peppard** and **Rintelmann**

■ Identification and Treatment of Chemically Dependent Women

PRESENTED BY: Department of Substance Abuse, Henry Ford Hospital-Maplegrove

This course is intended for physicians in primary care and general psychiatry who are interested in further developing their skills in the identification and treatment of chemically dependent women. The course will be presented in three components. The first section will be a general overview of the scope of the problem of chemical dependency in women and current theories of etiology. Special attention will be given to teenage women, women with young children, middle-aged women presenting with apparent somatic complaints, and elderly women with frequent related grieving for losses. The second section will include a discussion of the dynamic development of dependency and its integral denial/defense system. Commonly used criteria for identification and diagnosis of the problem will be presented along with issues of treatment, referral and follow-up. The third section provides further elucidation of the problem from the perspective of recovering women who tell their own stories, including that of iatrogenic dependency. The format will be lecture and panel presentation with associated question and answer periods.

COURSE DIRECTOR: Suzanne R. Parker, MD, West Bloomfield

PRESIDING: Anne C. Cunningham, PhD, East Lansing

SPEAKERS/SUBJECTS:

Suzanne R. Parker, MD, Physician-in-Charge of Psychiatry, Department of Substance Abuse, Henry Ford Hospital-Maplegrove, West Bloomfield
"The Denial System of Chemical Dependency"
"What is Treatment"
"Motivating the Patient to Treatment"
Anne C. Cunningham, PhD, Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine
"Scope of the Problem"
"Theories of Etiology"
Joan Vangel, MD, Physician-in-Charge of Medicine, Department of Substance Abuse, Henry Ford Hospital-Maplegrove, West Bloomfield
"Making the Diagnosis"
"Follow-Up of the Recovering Chemically Dependent"

■ Marijuana: Its Medical, Legal and Social Implications

PRESENTED BY: MSMS Section on Clinical Pharmacology and Therapeutics

In this course, marijuana will be reviewed primarily as a therapeutic agent in both its raw (natural) and synthetic forms. Laboratory assay for marijuana will be discussed as it relates to its medical relevance and drug interactions. A review of the drug for its risk/benefit ratio will be followed by a panel discussion.

COURSE DIRECTOR: George L. Royer, Jr., MD, Manager, Human Pharmacology, The Upjohn Company, Kalamazoo

PRESIDING: Doctor Royer

SPEAKERS/SUBJECTS:

Edward F. Domino, MD, Professor, Department of Pharmacology, University of Michigan Medical School
"Introduction and Overview"

Joseph T. Sobota, MD, Group Manager, Medical Development and Clinical Laboratory Research, The Upjohn Company, Kalamazoo
"Laboratory Aspects of Marijuana Use"
Robert Archer, PhD, Research Associate, Central Nervous System Research, Eli Lilly and Company, Indianapolis, Indiana
"The Place of Synthetic Cannabinoids in Medical Practice"
Michael Weintraub, MD, Associate Professor of Preventive Family and Rehabilitation Medicine, Departments of Pharmacology and Medicine, University of Rochester Medical Center, New York
"Review of the Therapeutic Applications of Marijuana"

■ New Developments and Old Myths About Hyperbaric Oxygen Therapy

PRESENTED BY: Michigan Chapter, American College of Chest Physicians

Intended for both primary and consulting physicians, this course will detail the current indications and uses for hyperbaric oxygen therapy. A combination of half-hour lectures and case presentations will be used to outline the physiologic responses to the hyperbaric environment and to illustrate how these responses may be used in the treatment of specific diseases. After completion of the course, the physician will understand the basics of hyperbaric medicine and be able to identify which of his patients might benefit from hyperbaric oxygen therapy.

COURSE DIRECTOR: Geoffrey R. Grambau, MD, Kalamazoo

PRESIDING: Doctor Grambau

SPEAKERS/SUBJECTS:

Geoffrey R. Grambau, MD, Co-Director, West Michigan Hyperbaric Unit, Bronson Methodist Hospital, Kalamazoo
"Introduction — History of Hyperbaric Medicine"
John W. Dircks, MD, Co-Director, West Michigan Hyperbaric Unit, Bronson Methodist Hospital, Kalamazoo
"Physics and Physiology of Hyperbaric Medicine"
Rodney Albrecht, RRT, Therapist in Charge, West Michigan Hyperbaric Unit, Bronson Methodist Hospital, Kalamazoo
"The Hyperbaric Chamber"
Doctor Grambau
"Treatment of Disease with Hyperbaric Oxygen"
Mr. Albrecht
"Safety, Side Effects, Procedures and Hyperbaric Oxygen"
Doctor Dircks
"Future of Hyperbaric Medicine"

■ Surgery for the Morbidly Obese

PRESENTED BY: Michigan Chapter, American College of Surgeons

This course will review indications, selection of patients, current surgical procedures, and results of surgery for the morbidly obese. It will aid physicians in identifying patients who would be candidates for surgical treatment as well as compare various past and present surgical techniques. The results of these procedures as well as long term management of patients will be presented. The format will include formal presentations followed by a panel discussion with adequate time for consideration of questions from attendees.

COURSE DIRECTOR: Robert D. Allaben, MD, Vice Chief of Surgery, Harper-Grace Hospitals; Associate Professor, Department of Surgery, Wayne State University School of Medicine

PRESIDING: Doctor Allaben

SPEAKERS/SUBJECTS:

Angelos A. Kambouris, MD, Head, Division of General Surgery, Henry Ford Hospital, Detroit; Clinical Associate Professor, Department of Surgery, University of Michigan Medical School
"Patient Selection and Evaluation"
John R. Kirkpatrick, MD, Chief, Section of General Surgery, Harper-Grace Hospitals, Detroit; Professor, Department of Surgery, Wayne State University School of Medicine
"Operative Procedures"
Richard E. Dean, MD, Professor, Division of Surgery, Michigan State University College of Human Medicine, Grand Rapids
"Maintenance of Optimal Nutrition on a Long Term Basis"
Kenneth J. Printen, MD, Clinical Professor, Department of Surgery, University of Iowa, Iowa City
"Results"

Complete and return registration form on page 19

Wednesday afternoon, Nov. 16
All courses run from 1:30 to 5 p.m. with half-hour break

■ Allergy Update: Asthma, Foods, and Stinging Insects

PRESENTED BY: Michigan Allergy Society

This course will review newer developments in three areas of allergic disease. The hour on asthma will emphasize etiology and management, the role of additives, challenge tests, immunotherapy, and medications during pregnancy. The hour on food allergy will detail "state of the art" diagnostic techniques and treatment, as well as controversial methods to be avoided. The hour on stinging insect allergy will cover management of the acute reaction, indications and efficacy of venom immunotherapy, and clarify when referral is in order. The lectures will each have a question and answer period.

COURSE DIRECTOR: Clyde R. Flory, Jr., MD, Lansing

PRESIDING: Doctor Flory

SPEAKERS/SUBJECTS:

Clyde R. Flory, Jr., MD, Associate Clinical Professor, Department of Medicine, Michigan State University College of Human Medicine; President, Michigan Allergy Society
"Asthma: Current Concepts and Management"

John Anderson, MD, Chairman, Department of Pediatrics; Division Head, Department of Allergy and Clinical Immunology, Henry Ford Hospital, Detroit; Chairman, Food Allergy Committee, American Academy of Allergy
"Food Allergy: Patients and Doctors Dilemma"

Robert W. Clausen, MD, Clinical Instructor, Department of Medicine, University of Michigan Medical School; Teaching Attending Physician, Department of Medicine, Henry Ford Hospital, Detroit
"Stinging Insect Allergy: Diagnosis and Management"

■ Current Management of Kidney Stone Disease

PRESENTED BY: Michigan Branch, American Urological Association

This course is designed to acquaint the general practitioner with current techniques of diagnosis, medical management, and surgical and noninvasive methods of eradications of renal calculi. Participants will also be introduced to new techniques such as the use of ultrasound in the management of kidney stones.

COURSE DIRECTOR: Joseph C. Cerny, MD, Chairman, Department of Urology, Henry Ford Hospital, Detroit

PRESIDING: Doctor Cerny

SPEAKERS/SUBJECTS:

Michael Kleerekoper, MD, Staff Endocrinologist, Henry Ford Hospital, Detroit
"Diagnosis and Medical Management of Kidney Stone Disease"

Ray H. Littleton, MD, Staff Urologist, Henry Ford Hospital, Detroit
"Percutaneous Nephrolithotomy"

Edward S. Lyon, MD, Associate Professor, Section of Urology, Department of Surgery, University of Chicago
"Ureteroscopy and Removal of Ureteral Calculi"

L. Paul Sonda, MD, Associate Professor, Section of Urology, Department of Surgery, University of Michigan Medical School
"The Current Role of Coagulum Pyelolithotomy and Anatropic Pyelolithotomy"

MOVIE — *"The Stone Machine"*

■ Ethical Issues in Ambulatory Care

PRESENTED BY: Medical Humanities Program, Michigan State University College of Human Medicine

Ethical issues abound in an office practice and include such questions as whether or not to grant a teenager's request for confidentiality, questionable prescriptions at the patient's request and truth-telling which might lead to embarrassing or family-disturbing consequences. The particular focus of this course will be informed consent and patient education. The format, which includes both a formal presentation and small group participation is designed for relevance to all practicing physicians and provides the opportunity for active practice in dealing with actual patient problems.

COURSE DIRECTOR: Andrew D. Hunt, MD, East Lansing

PRESIDING: Doctor Hunt

SPEAKERS:

Andrew D. Hunt, MD, Coordinator, Medical Humanities Program; Professor, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

Howard Brody, MD, PhD, Assistant Coordinator, Medical Humanities Program; Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine

Bruce Miller, PhD, Professor and Chairman, Department of Philosophy; Assistant Coordinator, Medical Humanities Program, Michigan State University College of Human Medicine

Daniel Bronstein, JD, Associate Professor, Departments of Resource Development, Psychiatry and Medical Humanities Program, Michigan State University College of Human Medicine

Shirley Bach, PhD, Professor, Department of Natural Science, Western Michigan University, Kalamazoo

■ Neurological Emergencies — An Approach

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This program is intended for emergency physicians, family physicians, and other primary care practitioners who must rapidly evaluate neurological complaints. A brief review of functional neuroanatomy will be given along with an approach to common neurologic problems such as altered mental status, stupor and coma, headache, loss of vision, weakness, dizziness, and hearing difficulties. Case studies will be presented to illustrate the neurological anatomy and physiology principles as they relate to clinical medicine.

COURSE DIRECTOR: Gregory L. Henry, MD, Ann Arbor

PRESIDING: Doctor Henry

SPEAKER/SUBJECT:

Gregory L. Henry, MD, Chief, Department of Emergency Medicine, Beyer Memorial Hospital, Ypsilanti; Clinical Instructor, Section of Emergency Medicine, University of Michigan Medical School
"Acute Neurological Emergencies"

■ Pediatric Orthopaedics For Family Practitioners

PRESENTED BY: Michigan Orthopaedic Society

This course, designed to be of general interest, will focus on common pediatric orthopaedic problems, their recognition, appropriate laboratory tests, treatment and outcome. Using a lecture and panel discussion format, subjects such as idiopathic rotatory problems, multiple handicaps, infections, scoliosis, oncology and trauma will be discussed. A panel at the end of the course will facilitate questions and answers and participants are encouraged to bring questions regarding their own cases.

COURSE DIRECTOR: Richard L. LaMont, MD, Chairman, Department of Orthopaedic Surgery, Wayne State University School of Medicine

PRESIDING: Jerome A. Conrad, MD, President, Michigan Orthopaedic Society

SPEAKERS/SUBJECTS:

Thomas F. Kling, MD, Assistant Professor, Section of Orthopaedic Surgery, University of Michigan Medical School
"Idiopathic Rotatory and Angular Problems in Children"
E. Dennis Lyne, MD, Head, Division of Pediatric Orthopaedic Surgery, Henry Ford Hospital, Detroit
"Management of the Multiply Handicapped Child"
Neal Marcus, MD, Senior Staff, Division of Pediatric Orthopaedic Surgery, Henry Ford Hospital, Detroit
"Orthopaedic Infections in Children"
Alvin Crawford, MD, Chairman, Department of Orthopaedics, University of Cincinnati, Ohio
"New Trends in Scoliosis"
Brian Hotchkiss, MD, Associate Clinical Professor, Department of Surgery, Michigan State University College of Human Medicine; Chairman, Department of Orthopaedic Surgery, Blodgett Memorial Medical Center, Grand Rapids
"Current Trends in Orthopaedic Oncology"
David D. Aronson, MD, Associate Chief, Department of Orthopaedics, Children's Hospital of Michigan, Detroit
"Diagnostic Problems in Orthopaedic Trauma"

PANEL PRESENTATION
Doctors **Aronson, Crawford, Hotchkiss, Kling, Lyne** and **Marcus**

■ Pediatric Otolaryngology

PRESENTED BY: Michigan Otolaryngological Society

This course will begin with an overview by a distinguished guest speaker on the topic of "pediatric otolaryngology and the laser experience." Following this, we will present a panel prepared to discuss such subjects as subglottic stenosis, laser and laryngoscopy, laryngeal papillomas, chronic and acute ear disease and epistaxis. The panel will be prepared to answer questions and would like to solicit problem cases from the audience for discussion. Participants are encouraged to come prepared to discuss such cases.

COURSE DIRECTOR: Bennie B. Gilmore, Jr., MD, Detroit

PRESIDING: Doctor Gilmore

SPEAKERS/SUBJECTS:

Gerald Healy, MD, Associate Professor, Department of Otolaryngology, Boston University School of Medicine and Harvard Medical School, Instructor in Otolaryngology, Tufts University School of Medicine; Otolaryngologist-in-Chief, Children's Hospital, Boston, Massachusetts
"Pediatric Otolaryngology and the Laser Experience"

PANEL PRESENTATION
Ronald S. Bogdasarian, MD, Assistant Professor, Department of Otolaryngology, University of Michigan Medical School
Walter Belenky, MD, Chief Pediatric Otorhinolaryngologist, Children's Hospital of Michigan, Detroit
Bennie B. Gilmore, Jr., MD, Assistant Professor, Department of Otolaryngology, University of Michigan Medical School; Senior Staff Physician, Department of Otolaryngology, Henry Ford Hospital, Detroit

■ Recent Advances in Neurology

PRESENTED BY: Michigan Neurological Association

This course will be presented in four main sections: Parkinson's, Movement Disorders, Myasthenia Gravis and Epilepsy. Within the sections we will include discussion of drug therapy, development of patient support groups, early and accurate diagnosis, hospital and outpatient management, new treatments, drug interactions, side effects and treatment of associated behavioral problems. We will utilize slides, lectures and movies to present the topics on a practical and updated level. Time will be provided for questions and answers.

COURSE DIRECTOR: Raymond B. Bauer, MD, Detroit

PRESIDING: Doctor Bauer

SPEAKERS/SUBJECTS:

Raymond B. Bauer, MD, Professor, Department of Neurology, Wayne State University School of Medicine
"Office and Hospital Management of Parkinson's Patients"
Anne B. Young, MD, Associate Professor, Department of Neurology, University of Michigan Medical School
"The Diagnosis and Treatment of Hyperkinetic Movement Disorders"
James W. Albers, MD, Associate Professor, Department of Neurology, University of Michigan Medical School
"Practical Evaluation and Management of Myasthenia Gravis"
Ernst Rodin, MD, Director, Epilepsy Center of Michigan, Detroit
"Modern Treatment of Epilepsy"

■ The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression, and Drug Abuse

PRESENTED BY: Michigan Psychiatric Society

This course will provide practical information for all physicians who deal directly or indirectly with adolescents in the differential diagnosis of the symptom of task incompletion, and its treatment. The relationship to neurosis, psychosis, depression, homosexuality, and drug abuse will be made with techniques and guidelines for the physician to utilize. Questions and discussion will be encouraged.

COURSE DIRECTOR: Sander J. Breiner, MD, Birmingham

PRESIDING: Doctor Breiner

SPEAKER/SUBJECT:

Sander J. Breiner, MD, Associate Professor, Department of Psychiatry, Michigan State University College of Human Medicine; Assistant Professor, Department of Psychiatry, Wayne State University School of Medicine
"The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression, and Drug Abuse"

■ What's New in the Management of Cutaneous Tumors

PRESENTED BY: Michigan Dermatological Society

This course will outline the basic approach to the differential diagnosis and treatment of basal cell carcinoma, squamous cell carcinoma, and melanoma. New approaches and complications of old approaches will be emphasized. In addition, the topic of laser therapy as it pertains to cutaneous disease will be discussed by a leading medical expert in the field

COURSE DIRECTOR: Neil A. Swanson, MD, Ann Arbor

PRESIDING: Doctor Swanson

SPEAKERS/SUBJECTS:

Neil A. Swanson, MD, Assistant Professor, Departments of Dermatology and Otolaryngology, University of Michigan Medical School
"Basal Cell Carcinoma — Treatment Overview and Mohs Surgery"

Richard F. Elton, MD, Associate Clinical Professor, Department of Dermatology, Wayne State University School of Medicine
"Cryosurgery: Use and Complications"

H. Gunter Seydel, MD, Professor and Chairman, Department of Therapeutic Radiology, Henry Ford Hospital, Detroit
"Radiation Therapy 1983"

Philip Bailin, MD, Professor and Chairman, Department of Dermatology, Cleveland Clinic, Ohio
"Laser Surgery: Theory and Applications"

John Niederhuber, MD, Professor, Department of Surgery, University of Michigan Medical School
"Melanoma Update"

At-a-glance schedule of ASM special events

Monday, Nov. 14	8:00 PM	MSMS/PSG Financial Planning Seminar, for physicians and spouses
Tuesday, Nov. 15	7:30 AM	Exhibit Hall Open
	11:45 AM	Deli luncheon, exhibit hall
	8:00 PM	MSMS/PSG Financial Planning Seminar, for physicians and spouses
	8:00 PM	Michigan Health Council "Wellness Workshop" for physicians and spouses
Wednesday, Nov. 16	7:30 AM	Exhibit Hall open
	11:45 AM	Deli luncheon, exhibit hall
	11:45 AM	Luncheon/Speaker Michigan Psychiatric Society Women's Issues Committee
	5:30 PM	Meeting, Reception and Dinner Michigan Society of General Surgeons
	6:00 PM	Reception and Dinner Michigan Branch, American Urological Association
		Reception Wayne State University Medical Alumni
		Reception and Dinner Michigan Otolaryngological Society
Thursday, Nov. 17	7:30 AM	Exhibit Hall open
	11:45 AM	Deli luncheon, exhibit hall
	Noon	Luncheon Meeting Foreign Medical Graduate Psychiatrists
	5:30 PM	Reception and Dinner Michigan Ophthalmological Society
	6:30 PM	Reception and Dinner Michigan Society of Colon and Rectal Surgeons

Your 55 courses offer 3 hours each of Category I credit

Thursday morning, Nov. 17

All courses run from 8:30 to noon with half-hour break

Basic Cardiac Life Support

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is being offered for those physicians who are not currently certified in Basic Life Support and who may wish to become certified. It will consist of basic lectures, including management of the airway and cardiac massage. Time will be provided for a practice session on the manikins, but prior CPR practice is highly recommended.

COURSE DIRECTOR: Robert K. Orr, DO, Lansing

PRESIDING: Doctor Orr

FACULTY:

Robert K. Orr, DO, Director, Emergency Medical Services, Lansing General Hospital; **Paul Berlin, A-EMT,** Midland Hospital; **Michael Gurecki, A-EMT,** Lansing Fire Department; **Jane Hedges, RN,** Lansing General Hospital; **Valorie Kinne,** BCLS Instructor, Lansing General Hospital; **Jack Lynch, A-EMT,** Meridian Township Fire Department; **Mary Ellen McCloy, RN,** Lansing General Hospital

Controversies and Advances in Trauma

PRESENTED BY: Department of Surgery, Wayne State University School of Medicine

This course will consist of a series of discussions for surgeons. The topics will deal with some of the most controversial subjects in the management of seriously injured patients. Discussion will be encouraged between the audience and panel members and representative case problems will be presented.

COURSE DIRECTOR: Robert F. Wilson, MD, Detroit

PRESIDING: Doctor Wilson

SPEAKERS/SUBJECTS:

Robert M. Nelson, MD, Assistant Professor, Department of Surgery, Wayne State University School of Medicine
"Antibiotics in Trauma"
Eti Gursel, MD, Assistant Professor, Department of Surgery, Wayne State University School of Medicine; Director, Burn Center, Detroit Receiving Hospital
"Severe Burns: Are Early Antibiotics Needed?"
"Are Steroids Needed for Severe Inhalation Injuries?"
John R. Kirkpatrick, MD, Professor, Department of Surgery, Wayne State University School of Medicine; Chief, Department of General Surgery, Harper Hospital, Detroit
"Risk vs. Benefit Controversy in Nutritional Support"
Robert F. Wilson, MD, Professor, Department of Surgery, Wayne State University School of Medicine; Chief, Department of Surgery, Detroit Receiving Hospital
"Severe Blunt Chest Trauma: When to do Arteriograms — When to Use Bypass"
"Flail Chest: Surgery? Ventilators?

Gastrointestinal Scintigraphy (Imaging)

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

This course will provide practical information to medical and surgical primary care physicians and consultants about the indications and uses of imaging (scintigraphy) in patients with hepato biliary problems, lower G.I. bleeding and gastric emptying disorders. A slide-lecture format will include case presentations as well. This program may also provide a review and update for radiologists and nuclear physicians not currently performing these studies.

COURSE DIRECTOR: Conrad E. Nagle, MD, Troy

PRESIDING: Doctor Nagle

SPEAKERS/SUBJECTS:

Darlene Fink-Bennett, MD, Assistant Director, Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak; Assistant Professor, Michigan State University College of Human Medicine
"Hepatobiliary Scintigraphy (Imaging)"
Conrad E. Nagle, MD, Chief, Department of Nuclear Medicine, William Beaumont Hospital, Troy
"Imaging in Lower Gastrointestinal Bleeding"
John E. Freitas, MD, Staff Physician, Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak; Clinical Associate Professor, Department of Medicine, University of Michigan Medical School
"Imaging Patients with Gastric Emptying Disorders"

Home Health Care Programs: Pediatrics and Adults

PRESENTED BY: MSMS Committee on Home Health Care and Department of Pediatrics, Bronson Methodist Hospital

This course will discuss the planning efforts and preparation needed for the provision of home health care for infants, children and adults. Topics for discussion will include chronic obstructive pulmonary disease and there will be specific focus on those patients requiring oxygen, tracheostomy and/or ventilator care in the home. Time will be reserved for participant discussion.

COURSE DIRECTOR: John V. Hartline, MD, Neonatologist; Co-Director, Newborn Intensive Care; Chief, Department of Pediatrics, Bronson Methodist Hospital, Kalamazoo.

PRESIDING: Doctor Hartline

SPEAKERS/SUBJECTS:

Marc Hargus, Medical Social Worker, Bronson Methodist Hospital, Kalamazoo
"Development of Home Care Programs for Infants and Children"

Charles L. Shabino, MD, Director, Pediatric Intensive Care Unit, Bronson Methodist Hospital, Kalamazoo
"Development of Home Care Programs for Infants and Children"

John E. Schoell, MD, Staff Physician, Department of Pulmonary Medicine, Bronson Methodist Hospital, Kalamazoo
"Home Care and Chronic Obstructive Pulmonary Disease (COPD)"

Hypertension — Current Therapeutic Update

PRESENTED BY: MSMS Section on Clinical Pharmacology and Therapeutics

In this course, an overview of therapy of hypertension will be presented with particular reference to the initial hypertensive workup, who to treat, definition and description of step therapy, and what is new in the treatment of resistant hypertension. A panel discussion with the audience will be held at the end of the program.

COURSE DIRECTOR: George L. Royer, Jr., MD, Manager, Human Pharmacology, The Upjohn Company, Kalamazoo

PRESIDING: Doctor Royer

SPEAKERS/SUBJECTS:

Stots B. Reele, MD, Senior Clinical Investigator, Bronson Clinical Investigational Unit, Bronson Methodist Hospital, Kalamazoo
"The Work-Up of the Hypertensive Patient"

Raymond H. Murray, MD, Professor and Chairman, Department of Medicine, Michigan State University College of Human Medicine
"Who to Treat"

Park W. Willis, III, MD, Professor, Department of Internal Medicine, Michigan State University College of Human Medicine
"How to Treat, Step Therapy, Etc."

Donald G. Vidt, MD, Head, Clinical Section, Department of Hypertension, Cleveland Clinic Foundation, Ohio
"New Drugs on the Horizon"

Medical Use of Lasers

PRESENTED BY: Section of Otolaryngology, Sinai Hospital of Detroit

This is a review course for general practitioners to familiarize themselves with the latest advancements in laser treatment for a variety of medical problems. An overview of ophthalmology, gastroenterology, otolaryngology, plastic surgery and oral surgery will be presented. In addition, basic concepts of how the laser works and techniques for anesthesia will also be discussed.

COURSE DIRECTOR: Eugene Rontal, MD, Clinical Assistant Professor, Section of Otolaryngology, Sinai Hospital of Detroit

PRESIDING: Doctor Rontal

SPEAKERS/SUBJECTS:

Hugh Beckman, MD, Chairman, Department of Ophthalmology, Sinai Hospital of Detroit; Clinical Associate Professor, Department of Ophthalmology, Wayne State University School of Medicine
"Use of Lasers in Ophthalmology"

Milton H. Goldrath, MD, Chairman, Department of Obstetrics and Gynecology, Sinai Hospital of Detroit; Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine
"Use of Lasers in Gynecology"

Terry Fuller, PhD, Director of Laser Program, Sinai Hospital of Detroit
"Basic Concepts in Use of Laser"

Michael Rontal, MD, Co-Chief, Section of Otolaryngology, Sinai Hospital of Detroit; Clinical Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine
"Use of Lasers in Otolaryngology"

Arthur Klass, MD, Attending Physician, Sinai Hospital of Detroit; Clinical Assistant Professor, Department of Internal Medicine, Wayne State University School of Medicine
"Use of Lasers in Gastroenterology"

Frederick Weissman, MD, Clinical Assistant Professor, Department of Plastic Surgery, Sinai Hospital of Detroit; Clinical Assistant Professor, Departments of Surgery and Medicine, Wayne State University School of Medicine
"Use of Lasers in Plastic Surgery"

Recent Advances in Pediatric Hematology

PRESENTED BY: Department of Pediatrics, Mott Children's Hospital, University of Michigan Medical School

This course will instruct primary consulting physicians in the newer diagnostic and therapeutic approaches to management of patients with childhood acute leukemias, lymphomas, Wilms' tumor, and neuroblastoma. Becauses many of these diseases are complicated by neutropenia either arising from marrow infiltration or from the effects of chemotherapy, a brief discussion will be provided detailing the management of the patient with neutropenia.

COURSE DIRECTOR: Laurence A. Boxer, MD, Ann Arbor

PRESIDING: Doctor Boxer

SPEAKERS/SUBJECTS:

David N. Shapiro, MD, Department of Hematology/Oncology, C.S. Mott Children's Hospital, University of Michigan Medical School
"Childhood Acute Leukemia Update"

Raymond J. Hutchinson, MD, Assistant Professor, Department of Pediatrics, C.S. Mott Children's Hospital, University of Michigan Medical School
"Management of the Child with Non-Hodgkin's and Hodgkin's Lymphoma"

Laurence A. Boxer, MD, Professor, Department of Pediatrics; Director, Department of Pediatric Hematology/Oncology, C.S. Mott Children's Hospital, University of Michigan Medical School
"Management of the Patient with Neutropenia"

John R. Wesley, MD, Associate Professor, Department of Surgery, C.S. Mott Children's Hospital, University of Michigan Medical School
"Evaluation of Management of Patients with Wilms' Tumor and Neuroblastoma"

Scar Control

PRESENTED BY: Michigan Academy of Plastic Surgeons

Doctor Albert Borges, the author of a book on scar control, will discuss basic concepts and techniques of scar revisions which will be followed by open discussion of difficult cases and specific problems. An update of periprosthetic breast scar capsule control will be presented and will include the review of recent literature and experimental work, as well as utilization of special techniques, both those which have worked and those that have not. Doctor Borges will discuss in detail the Rhombic flap. Although the specific problems discussed are those routinely encountered by plastic surgeons, the basic concepts of scar control will be of wide interest to many physicians.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Detroit

PRESIDING: Doctor Ditmars

SPEAKERS/SUBJECTS:

Albert F. Borges, Plastic Surgeon, Falls Church, Virginia
"Scar Revisions" and "The Rhombic Flap"
Donald M. Ditmars, Jr., MD, Head, Division of Plastic and Reconstructive Surgery, Henry Ford Hospital; Clinical Assistant Professor, University of Michigan Medical School
"Periprosthetic Breast Scar Capsules: Experimental Review"
Robert M. O'Neal, MD, Clinical Associate Professor, Department of Surgery, Section of Plastic Surgery, University of Michigan Medical School; Staff Surgeon, St. Joseph Mercy Hospital, Detroit
"Attempts at Control of Periprosthetic Scar with Steriods, Low Bleed Prostheses, and Submuscular Implantation"
Joseph E. Mark, MD, Department of Plastic and Reconstructive Surgery, Crittenton Hospital, Rochester
"Polyurethane-Covered Prostheses"

■ Vision

PRESENTED BY: Michigan Ophthalmological Society

This course, which is aimed at the general physician, will discuss various aspects on the subject of vision, including anatomy and physiology, methods for dealing with visual disabilities, standards for measuring sight, and the visual pathway to the brain. We will also include brief discussion on types of glasses, contact lenses and intraocular lenses. We plan to include a practical session using the ophthalmoscope in detecting local, distant and systemic disease. Participants are encouraged to bring ophthalmoscopes for this portion of the program.

COURSE DIRECTOR: Frederick W. Bryant, MD, Department of Ophthalmology, William Beaumont Hospital, Royal Oak

PRESIDING: Doctor Bryant

SPEAKERS:

John P. Clune, MD, General Ophthalmologist; Assistant Clinical Professor, Kresge Eye Institute, Detroit
William T. Sallee, MD, Attending Physician, William Beaumont Hospital, Royal Oak

Thursday afternoon, Nov. 17

All courses run from 1:30 to 5 p.m. with half-hour break

■ Common Gastrointestinal Problems in Children: Diagnosis and Management

PRESENTED BY: Department of Gastroenterology, University of Michigan Medical School

Chronic diarrhea of infancy, encoparesis in the preschool child, and chronic abdominal pain in the older child or adolescent are frequent and troublesome problems. This course will review both the organic and nonorganic causes of these complaints, present a systematic approach to evaluation, and finally, provide information on management alternatives. The presentation will be didactic with ample time for questions and answers.

COURSE DIRECTOR: William J. Byrne, MD, Ann Arbor

PRESIDING: Doctor Byrne

SPEAKERS/SUBJECTS:

William J. Byrne, MD, Associate Professor, Department of Pediatrics; Director, Section of Gastroenterology, University of Michigan Medical School
"Abdominal Pain in Children: Current Thoughts on an Old Problem"
Lucyndia R. Marino, MD, Assistant Professor, Department of Pediatrics, Section of Gastroenterology, University of Michigan Medical School
"A Practical Approach to the Child with Encoparesis"
Doctor Byrne
"Chronic Diarrhea of Infancy: Evaluation and Management"

■ Conservative Treatment of Low Back Pain

PRESENTED BY: Michigan Academy of Physical Medicine and Rehabilitation

This course is directed towards the practicing physician who is the primary care provider for patients with low back pain. The format will be a lecture-slide presentation with a concluding panel discussion for answering questions. Basic concepts in the evaluation and conservative management will be reviewed with some emphasis on the multidisciplinary approach. The objective of the course is to enable the practicing physician to more confidently evaluate and manage this common, but complicated condition.

COURSE DIRECTOR: R. Larry Joynt, MD, Assistant Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine; Director, Residency Programming, Rehabilitation Institute of Metropolitan Detroit

PRESIDING: Doctor Joynt

SPEAKERS/SUBJECTS:

Michael Sperl, MD, Staff Psychiatrist, Sinai Hospital of Detroit; Consulting Psychiatrist, Henry Ford Hospital, Detroit
"Basic Concepts of Low Back Anatomy"
Harry O. Ingberg, MD, Associate Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine; Medical Director, Rehabilitation Institute of Metropolitan Detroit; Chief, Department of Physical Medicine and Rehabilitation, Harper Hospital, Detroit

Thursday afternoon/*continued*

"Evaluation of the Low Back Pain Patient"

Joseph R. Meerschaert, MD, Clinical Assistant Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine; Attending Staff, William Beaumont Hospital, Royal Oak

"Management of the Acute Low Back Problem"

Randy S. Roth, PhD, Clinical Psychologist and Director, Pain Management Program; Clinical Instructor, Department of Physical Medicine and Rehabilitation, University of Michigan Medical School

"The Multidisciplinary Treatment of Chronic Low Back Pain"

■ Diagnostic and Therapeutic Interventional Radiology

PRESENTED BY: Michigan Radiological Society

This course will review the role of the radiologist in diagnostic and therapeutic procedures utilizing catheters and needles guided by fluoroscopy, ultrasound and computed tomography. We will discuss in detail the advantages of fine needle aspiration biopsy for solid and cystic masses in the abdomen and percutaneous abscess drainages utilizing both ultrasound and computed tomographic guidance. Vascular interventional techniques including angioplasty, fibrinolysin therapy, embolization and chemotherapeutic infusion will be reviewed and illustrated. We will introduce newer interventional techniques in urology including nephrostomy, stone dissolution and removal. Interventional techniques in neuroradiology, primarily embolizations, will be discussed. Finally, the clinical implications of these techniques will be addressed by a surgical colleague. Ample time will be left for questions and discussion.

COURSE DIRECTOR: Robert L. Bree, MD, Royal Oak

PRESIDING: Doctor Bree

SPEAKERS/SUBJECTS:

Robert L. Bree, MD, Director, Division of Ultrasound, Department of Radiology, William Beaumont Hospital; Clinical Associate Professor, Department of Radiology, University of Michigan Medical School

"Interventional Techniques Utilizing CT and Ultrasound: Biopsies and Aspirations"

Robert A. Ellwood, MD, Director, Department of Vascular Radiology, William Beaumont Hospital, Royal Oak

"Interventional Angiographic Techniques in the Abdomen"

James Catto, Jr., MD, Department of Surgery, William Beaumont Hospital, Royal Oak

"Clinical Applications and Implications of Interventional Radiology"

Peter Moorton, DO, Department of Radiology, Bi-County Community Hospital, Warren

"Interventional Techniques in Urology"

Harvey Wilner, MD, Chief, Section of Neuroradiology, Department of Radiology, Harper Hospital; Associate Professor, Department of Neuroradiology, Wayne State University School of Medicine

"Interventional Neuroradiology"

■ Ophthalmic Outpatient Procedures

PRESENTED BY: Michigan Ophthalmological Society

This course, designed for ophthalmologists, will focus on specific ophthalmic procedures and the current trend toward performing them on an outpatient basis. Some of the topics for discussion include one-day hospitalization, office surgery and an update on specific procedures such as laser therapy. Time will be reserved for questions and participation from the audience.

COURSE DIRECTOR: Frederick W. Bryant, MD, Department of Ophthalmology, William Beaumont Hospital, Royal Oak

PRESIDING: Doctor Bryant

SPEAKERS

Philip C. Hessburg, MD, Medical Director, Detroit Institute of Ophthalmology

John Balin, MD, Ophthalmologist, Rochester;

Edward R. O'Malley, MD, Pediatric Ophthalmologist, Detroit Institute of Ophthalmology

Ted Wojno, MD, Kellogg Eye Center, Ann Arbor

Hugh Beckman, MD, Chairman, Department of Ophthalmology, Sinai Hospital of Detroit; Clinical Associate Professor, Department of Ophthalmology, Wayne State University School of Medicine

■ Selected Topics in Pediatric Ambulatory Medicine

PRESENTED BY: Department of Pediatrics, University of Michigan Medical School

This course was designed to provide practical information about a number of current problems in ambulatory pediatric care. The problems were chosen because scientific or social change have resulted in new benefits or risks to patients. Time will be provided for questions and answers.

COURSE DIRECTOR: Robert C. Kelsch, MD, Ann Arbor

PRESIDING: Doctor Kelsch

SPEAKERS/SUBJECTS:

Martin E. Hurwitz, MD, Clinical Assistant Professor, Department of Pediatrics, University of Michigan Medical School

"Sympathomimetic Agents Use and Complications in Treating Children with Asthma"

Janet R. Gilsdorf, MD, Assistant Professor, Department of Pediatrics, University of Michigan Medical School

"Role of Primary Physician in Control of Infectious Diseases in Day Care Centers"

Patricia A. O'Connor, MD, Associate Professor, Department of Pediatrics, University of Michigan Medical School

"Starvation in Breast-Fed Infants"

Robert C. Kelsch, MD, Professor, Department of Pediatrics, University of Michigan Medical School

"Some Areas of Controversy in Management of UTI in Children"

■ Treatment of Arthritis

PRESENTED BY: Michigan Rheumatism Society

This course will provide primary physicians with information that will enable them to appropriately use aspirin and nonsteroidal anit-inflammatory drugs in the initial treatment of rheumatoid arthritis. Indication for the use of Intra-Articular Injection, Gold, or Penicillamine therapy will be reviewed. Physicians will be appraised of alternative therapies that may, in the near future, affect treatment decisions. The course will then consider present approaches to the treatment of osteoporosis, based on the extensive experience of the Henry Ford Hospital. Finally, physicians will be provided with practical information on the office treatment of vasculitis.

COURSE DIRECTOR: Joseph J. Weiss, MD, Consulting Physician, Wayne County General Hospital, Wayne

PRESIDING: Doctor Weiss

SPEAKERS/SUBJECTS:

James T. Cassidy, MD, Professor, Department of Internal Medicine, University of Michigan Medical School
"Acetylsalicylic Acid and Non-Steroidal Anti-Inflammatory Drugs and Intra-Articular Injection in the Treatment of Rheumatoid Arthritis"

Joseph McCune, MD, Assistant Professor, Department of Internal Medicine, University of Michigan Medical School
"Gold, Penicillamine, Steroids, and Other Therapies in the Treatment of Rheumatoid Arthritis"

Howard Duncan, MD, Director, Department of Rheumatology, Henry Ford Hospital, Detroit
"Treatment of Osteoporosis"

Felix R. Fernandez-Madrid, MD, PhD, Professor, Department of Internal Medicine, Wayne State University School of Medicine
"Newer Concepts in the Treatment of Vasculitis"

■ Unique Techniques in Plastic Surgery

PRESENTED BY: Michigan Academy of Plastic Surgeons

Plastic surgery by its nature tends to be a very individualized practice with some techniques not being widely publicized for varying reasons. Many surgeons believe they have developed certain modifications not frequently practiced by other surgeons and that might be too trivial for publication. Other busy practitioners have just not had time to publish sometimes very important concepts. The speakers will be limited to 20 minutes to present their individual concepts. The topics were selected because of their broad interest among plastic surgeons. Adequate discussion periods will follow each presentation.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Detroit

PRESIDING: Doctor Ditmars

SPEAKERS/SUBJECTS:

Albert F. Borges, MD, Plastic Surgeon, Falls Church, Virginia.
"Direct Rhytidectomy"

Robert Pool, MD, Chief, Department of Plastic and Reconstructive Surgery, William Beaumont Hospital, Royal Oak
"Non-Surgical Lip Adhesions"

Jorge Gomez, MD, Associate Clinical Professor, Department of Surgery, Michigan State University College of Human Medicine
"Bean Bag Positioning for Lastissimus Dorsi Flap"
"Lengthening of First Metacarpal of Amputated Finger"

Richard Straith, MD, Administrator, Straith Memorial Hospital, Southfield
"New Instrumentation for Suction Lipectomy"

Hashim Alani, MD, Plastic, Reconstructive and Laser Surgery, Sinai Hospital of Detroit, Providence Hospital, Southfield and Mt. Carmel Mercy Hospital, Detroit
"Experience with Laser Treatment of Cutaneous Lesions"

Donald M. Ditmars, Jr., MD, Head, Division of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit; Clinical Assistant Professor, Department of Surgery, University of Michigan Medical School.
"Needle Tenovaginotomy for Trigger Fingers"

■ Update on Common Anorectal Problems

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This course, designed to be of interest for primary care physicians as well as surgeons, will present updated information and techniques in diagnosis and treatment of the most common anorectal diseases and problems found in North America. Topics to be discussed include fistulae, hermorrhoids, pruritis ani, fissures and ulcers and pilonidal disease.

COURSE DIRECTOR: W. Patrick Mazier, MD, Colon/Rectal Surgeon, Ferguson-Droste Clinic, Grand Rapids

PRESIDING: Doctor Mazier

SPEAKERS/SUBJECTS:

Khatchadour Hamamdjian, MD, Colon/Rectal Surgeon, Lathrup Village
"Fistulae"

John M. MacKeigan, MD, Colon/Rectal Surgeon, Ferguson-Droste Clinic, Grand Rapids
"Hemorrhoids"

Steven E. Olchowski, MD, Colon/Rectal Surgeon, Saint Clair Shores
"Pruritus Ani"

Steven Klein, MD, Colon/Rectal Surgeon, Southfield
"Fissures and Ulcers"

William L. Beauregard, MD, Program Director, Colon/Rectal Surgery Training Program, William Beaumont Hospital, Royal Oak
"Pilonidal Disease"

■ What's New in Dermatology

PRESENTED BY: Michigan Dermatological Society

This course will outline for the practitioner new concepts and approaches to common cutaneous diseases. New therapies will be discussed in detail for use in the office as well as on a referral basis.

COURSE DIRECTOR: Neil A. Swanson, MD, Assistant Professor, Departments of Dermatology and Otolaryngology, University of Michigan Medical School

PRESIDING: Doctor Swanson

SPEAKERS/SUBJECTS:

James E. Rasmussen, MD, Professor, Departments of Dermatology and Pediatrics, University of Michigan Medical School
"What's New With Kids"

Charles N. Ellis, MD, Assistant Professor, Department of Dermatology, University of Michigan Medical School
"Acne and Retinoids"

Roy C. Grekin, MD, Instructor, Department of Dermatology, University of Michigan Medical School
"Acne Surgery and Zyderm"

Andrew J. Mitchell, MD, Assistant Clinical Professor, Department of Dermatology, University of Michigan Medical School; Staff Physician, Department of Dermatology, Henry Ford Hospital, Detroit
"Alopecia Areata"
"Pathogenesis and Phototherapy"

Evelyn E. Vanderveen, MD, Chief Resident, Department of Dermatology, University of Michigan Medical School
"Contact Sensitizers and Minoxodil"

Edward A. Krull, MD, Chairman, Department of Dermatology, Henry Ford Hospital, Detroit
"Androgenic Alopecia — Surgical Treatment"

PLEASE SEND ENTIRE PAGE WITH CHECK

1983 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

*All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.

TUESDAY MORNING, NOV. 15

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Cancer Patient Management in the 1980s: The Role of Radiation Oncology
____ Child Abuse: How to Make the System Work for Your Patient
____ Diabetes — Current Management and New Developments
____ Emergency Psychiatry for the Non-Psychiatrist
____ Evaluation and Management of Infertile Couples
* ____ Flow Cytometry: Clinical Application
____ Helping the Troubled Employee: The Role of Physicians and Industry
____ Medically-Related Communications Impairments: The Physician's Role
____ Traumatic Injuries to the Head, Spine, and Peripheral Nerves

TUESDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Adding Life to Years: Meeting the Needs of the Aged
* ____ An Overview of the Human Health Effects of Nuclear Weapons
____ Chronic Drug Therapy and the Surgical Patient
____ Diagnosis and Management of Pelvic Pain
____ High Quality Care With DRGs
____ Medical Genetics for the Practicing Physician
____ Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal
____ Pediatric Immunology Infectious Diseases New Concepts and Treatment Modalities
____ Some Burning Issues in Gastroenterology

WEDNESDAY MORNING, NOV. 16

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ A Comprehensive Review of Anorexia Nervosa
____ Arm Pain and Dysfunction: Diagnosis and Management
____ Basic Cardiac Life Support
____ Esophageal Disorders for the General Physician
____ Evaluation and Treatment of the Dizzy Patient
____ Identification and Treatment of Chemically Dependent Women
____ Marijuana — Its Medical, Legal, and Social Implications
____ New Developments and Old Myths About Hyperbaric Oxygen Therapy
____ Surgery for the Morbidly Obese

WEDNESDAY AFTERNOON, NOV. 16

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Allergy Update: Asthma, Foods, and Stinging Insects
____ Current Management of Kidney Stone Disease
____ Ethical Issues in Ambulatory Care
____ Neurological Emergencies — An Approach
____ Pediatric Orthopaedics for Family Practitioners
____ Pediatric Otolaryngology
____ Recent Advances in Neurology
____ The Adolescent Who Doesn't Finish Any Task Relationship to Psychosis, Depression and Drug Abuse
* ____ What's New in the Management of Cutaneous Tumors

THURSDAY MORNING, NOV. 17

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Controversies and Advances in Trauma
____ Gastrointestinal Scintigraphy (Imaging)
____ Home Health Care Programs: Pediatrics and Adults
____ Hypertension — Current Therapeutic Update
* ____ Medical Use of Lasers
____ Recent Advances in Pediatric Hematology
____ Scar Control
____ Vision

THURSDAY AFTERNOON, NOV. 17

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Common Gastrointestinal Problems in Children: Diagnosis and Management
____ Conservative Treatment of Low Back Pain
____ Diagnostic and Therapeutic Interventional Radiology
* ____ Ophthalmic Outpatient Procedures
____ Selected Topics in Pediatric Ambulatory Medicine
____ Treatment of Arthritis
* ____ Unique Techniques in Plastic Surgery
____ Update on Common Anorectal Problems
____ What's New in Dermatology

The half-day courses will provide three hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/24/83 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, (313) 593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

Name ____________________
(please print) (first) (initial) (last)

Street ____________________

City, State ____________________ ZIP ________ ________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ____________ Other ____

Tuition Schedule for Courses:

MSMS members: $6 per credit hour, or $18 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $12 per credit hour, or $36 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ________ Wednesday lunch ________ Thursday lunch ________
- Indicate total number of half-day courses:

	____ x $18 (members)	$ ________
	____ x $ 9 (retired)	$ ________
	____ x $36 (non-members)	$ ________
	____ x $ 5 (residents)	$ ________

- Please enroll me in the MSMS/PSG seminars, being held from 8-10 p.m. (Physicians' guests are free.)

Mon. 11/14 "Investment Alternatives for the '80s":	____ ($10 fee)	$ ________
Tue. 11/15 "Retirement Plans: Living with TEFRA":	____ ($10 fee)	$ ________
TOTAL		$ ________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

Here are 65 good reasons to visit ASM exhibit hall

There are 65 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn.

The trained professional representatives of 65 firms will be awaiting the opportunity to discuss with physicians the details of their products and services in a relaxed atmosphere, where there are:

No patients awaiting care.
No emergencies.
No office management problems.

The exhibit hall is an important part of the Annual Scientific Meeting, and is the site of registration for all courses and special events. In addition, the deli luncheons offered by MSMS to all Annual Scientific Meeting participants, and after-hours beer breaks are staged in the exhibit area.

To help MSMS members plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

Pharmaceuticals

- Adria Laboratories, Inc.
- Ayerst Laboratories
- Boehringer Ingelheim
- Bristol Laboratories
- Dista Products Company
- Eli Lilly and Company
- Hoechst-Roussel Pharmaceuticals
- Parke-Davis Company
- Reed and Carnrick
- Ross Laboratories
- Searle Laboratories
- Smith Kline and French Laboratories
- Smith Kline and French Cardiovasculars
- Syntex Laboratories
- The Upjohn Company

In-office equipment and support

- City Xray Company
- Cryomedics
- E & M Medical Systems
- Firestone X-ray Corp.
- Tom Herbst and Associates
- Michigan Bell
- Michigan Scanning Services
- ProMed, Inc.
- Vascular Diagnostic Instruments

Clinical laboratories

- Advance Medical and Research
- Allied Integrated Diagnostic Services
- Dearborn Clinical Lab.
- MetPath Inc.
- Oakland Diagnostic Laboratory
- Quality Clinical Laboratories, Inc.
- WMPC Toxicology Laboratory

Patient home care

- American Hospital Equipment Company
- American Orthopedic Service
- AminoMed Inc.
- Comedco, Inc.
- Computer Terminal Services, Inc.
- Gerber Products Company
- Home Oxygen Medical Equipment
- Ross Laboratories
- White and White

Computers/computer services

- Bennethum Computer Systems
- Data-Med Corporation
- Engram Medical Management Systems
- GTE Telenet Communications Corporation
- Medical Administrative Computer Services
- Medpac/Computer Methods Corporation
- Michigan Medical Services
- Professional Billing Inc.
- Rollins Medical/Dental Systems
- T/Com Computerized Insurance Billing Systems

Education resources

- Milex of Michigan
- W.B. Saunders

Protection

- Blue Cross Blue Shield
- First Heritage Corporation
- The Medical Protective Company
- Michigan Physicians Mutual Liability Company
- Physician Insurance Company of Michigan
- Stratton-Cheeseman and Associates, Inc.

Career alternatives

- U.S. Air Force
- U.S. Army

Other exhibitors

- Hack Shoe Company
- Health Care News
- McCullagh Leasing — car leasing
- Metro Vehicle Consultants — car leasing
- Michigan Ophthalmological Society

MEDIGRAM

Michigan State Medical Society
120 West Saginaw Street
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Editor: Judith Marr

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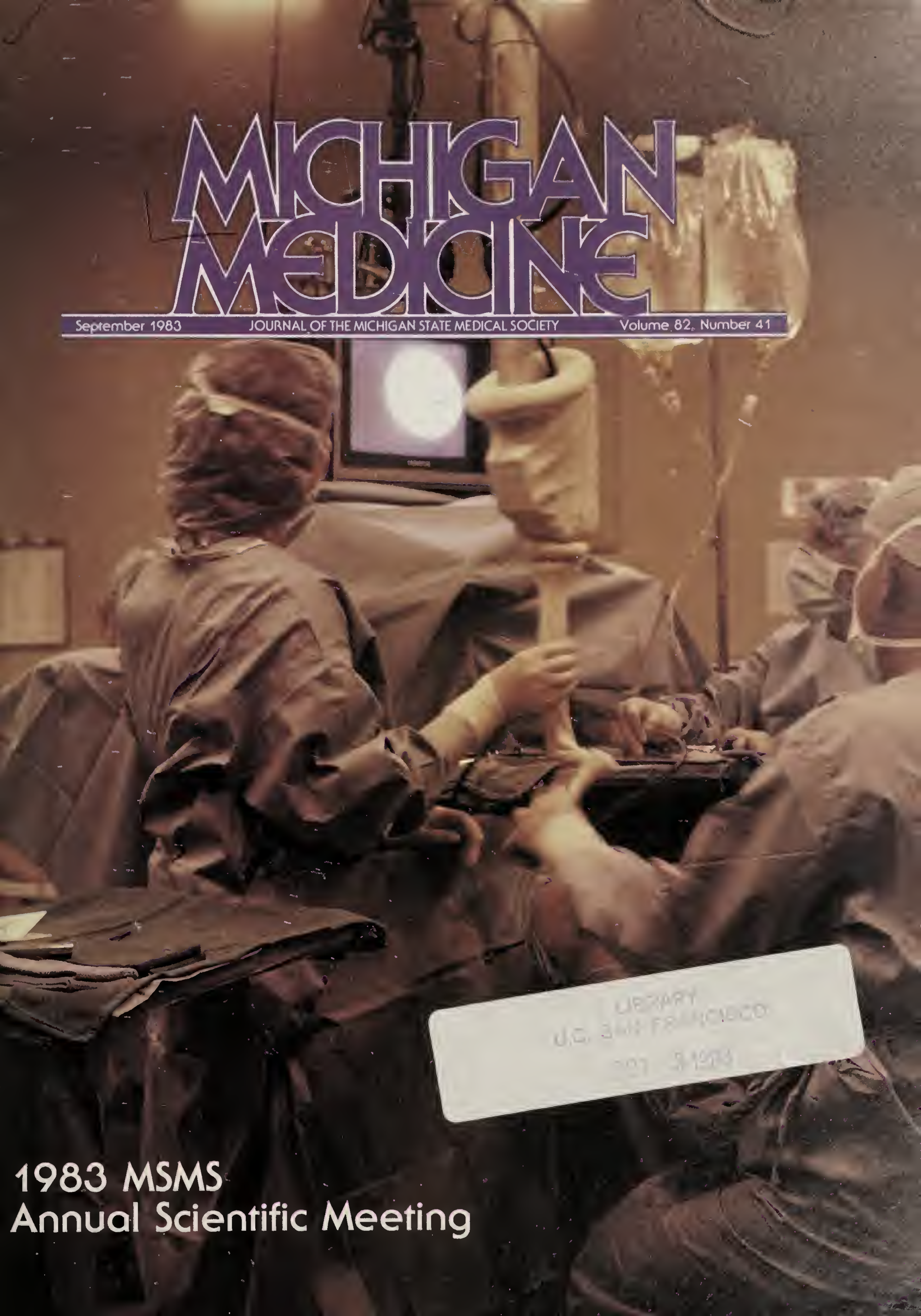

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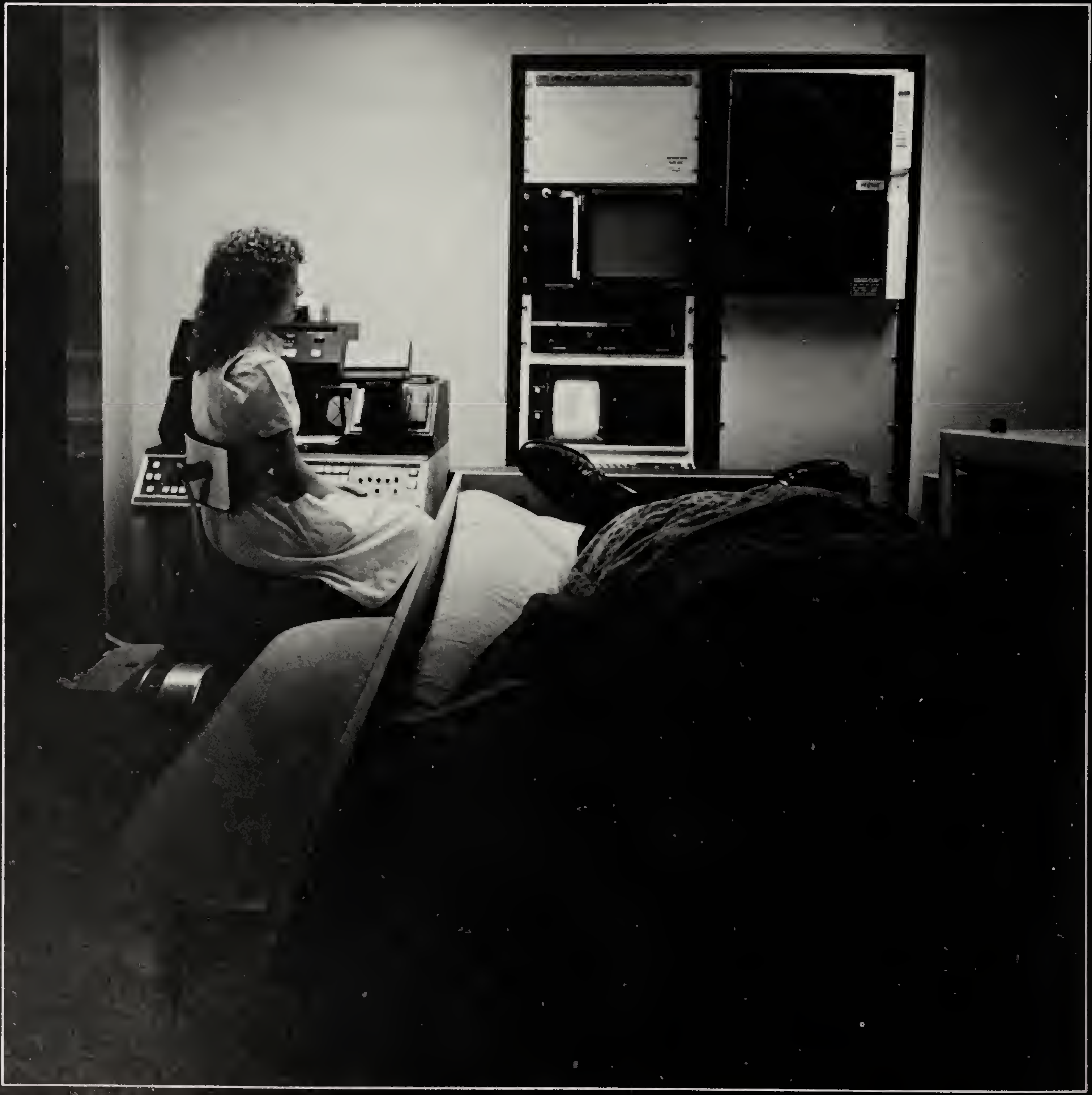
1983 MSMS Annual Scientific Meeting

MSMS puts *You* in touch with high tech

Technology can improve patient care, but it needs your touch. The 1983 MSMS Annual Scientific Meeting offers you 55 CME courses ranging from nuclear medicine to counseling for abuse. Make your choice and earn up to 18 hours of Category I Credit. Let MSMS help you "keep in touch."



1983 MSMS ANNUAL SCIENTIFIC MEETING
November 15-16-17, 1983 Hyatt Regency Dearborn

1983 MSMS
Annual Scientific Meeting

This month's cover focuses on arthroscopy, one of the many technological procedures available to physicians today which will be discussed at the 1983 MSMS Annual Scientific Meeting. The meeting is the subject of our special report beginning on page 508. **(Photo by Kim Kauffman)**

MICHIGAN MEDICINE
September 1983, Vol. 82, No. 41

Special report

508 MSMS puts you in touch with high tech through its 1983 Annual Scientific Meeting, Nov. 15-17 at the Hyatt Regency Dearborn. From this page to the last one, articles in this issue provide you with the program details. Inside are pictures of the course directors, who describe in their own words why MSMS members will benefit from attending their courses. We provide information about speakers and exhibitors and print the full registration form. Begin today to make your plans to attend!

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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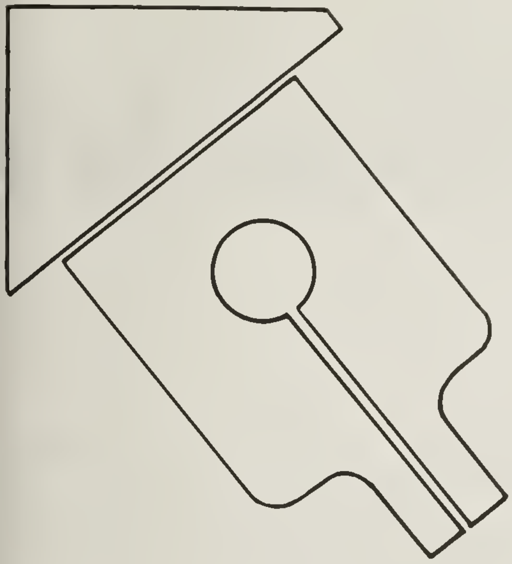
LETTERS



So what if health care is more than 10% of GNP?

Recent front page articles in Detroit newspapers about increasing child abuse could not help but stimulate all doctors involved with these problems to rethink this issue, which is after all a medical problem, and to look for ways that we as physicians should be doing more than we already are about it. Unfortunately it seems that prevention is really the key. This means preventing the frustrations which culminate in child abuse. This means providing jobs.

Many of our patients' problems are rooted in economics, poor housing and destructive lifestyles. When we see the nutritional deficiencies which result, when we treat the sequellae of alcoholism, drug abuse, prematurity and advance neglected disease, we are repeatedly reminded that these are all medical problems. As such, we physicians are enormously interested in their prevention. The word prevention is even a fashionable buzz word today. In fact we often read that physicians shortsightedly concentrate on treatment more than we do on prevention, which would be both more productive and more economical.

Much of this is true. The bind is that much of life is a medical problem. Most things that we do impact on our health. Diet, exercise, the fit of our shoes, our household heating system, and the psychological state of the unemployed are all medical issues. We and society both know that, but there is an ever swelling chorus of protest if "health costs" (whatever these are) rise at a rate greater than inflation. Good heavens, they are now over 10% of the gross national product! How about "legal care" costs, or "accountancy care?" Has anyone added up the costs, direct and indirect, of all types of insurance coverage in the USA per year?

We physicians are probably not doing enough today in the area of prevention, but if we did more our percentage of the gross national product would only rise further.

It is time for us and society to realize that health care already has been redefined in our society, and that it could stand even further redefinition. If much of life is intimately intertwined with health care, then "health care" costs should be well over 10% of the gross national product. This does not mean that more dollars should go to doctors. Don't worry. They won't. Even now less and less health care is rendered by doctors, more and more by nurses, social workers, limited license practitioners and paraprofessionals.

The screening that we keep hearing about health care is simply unrealistic. Such companies as Chrysler want better health care for its workers, provided more cheaply than ever, with more preventative services than ever. Good luck.

Back to child abuse — what we read and what we see of child abuse is revolting. We as doctors must look into expanded mental health clinics, parents' groups and day care centers. The foster care system also needs improvement. Our colleagues in public health have to study more intensively the alternative approaches available.

Last, or perhaps first, it all must be funded. Fine. Let us be honest about what needs to be done. If many of these social services are to be redefined as health care services — so be it. Then let us not get apoplectic if health care services even exceed 10% of the gross national product. If they do, so what?

Susan E. Adelman, MD
President
Wayne County Medical Society

Beautiful cover

Strikingly beautiful cover on July issue of *Michigan Medicine*. You do have an eye for a great picture.

Thought you would like to know how at least one MSMS member felt about it (but certain you will receive many similar comments).

Rodman Jacobi, MD
East Lansing

Deserving doctor

***Michigan Medicine* is happy to share the following letters about a member with his colleagues around the state. The letter originally was sent to the AMA headquarters in Chicago.**

In behalf of my mother, Mrs. Rachel Joseph, of Flint, I am taking time to express our appreciation and gratitude to Pradyumna Kuver, MD, of that city.

I feel Doctor Kuver is deserving of this commendation first for his dedication to his profession and second for his concerns and compassion for his patient, Mrs. Joseph, 83 years old.

Doctor Kuver has done wonders in treating Mrs. Joseph in a crisis and has spent time with her at the hospital. This world has always set a high value on dedication.

Doctor Kuver does exemplify this dedication; he does render fine quality medical care to all of his patients.

I wish the AMA to be aware of our appreciation and to convey to Doctor Kuver these thoughts on my behalf.

Simon Joseph
Flint

Here is Doctor Sammon's follow-up letter:

Dear Doctor Kuver:

Recently I had a letter from Mr. Simon Joseph, a relative of a patient of yours. He wrote to tell me of your dedicated and compassionate care for his mother, Mrs. Rachel Joseph.

What a joy to get letters like that about physicians such as you. You are certainly deserving of commendation.

On behalf of the American Medical Association's Board of Trustees, thank you for your many sincere efforts for your patients. Best wishes for continued success.

James H. Sammons, MD
Executive Director
AMA

SPECIAL REPORT

MSMS puts You in

By Sheri W. Greenhoe
East Lansing

Because today's physician is called upon to provide the vital 'high touch' that bridges the gap between high tech and the patient, MSMS will provide several opportunities for doctors to meet this challenge at the 1983 Annual Scientific Meeting.

A dozen courses addressing the personal aspects of medical practice will be offered. They enhance the many courses designed to build physician's technological knowledge and skills. All 12 'high touch' courses respond to MSMS President Crandall's call for members to "assimilate the technological advances of this rapidly growing field and apply them with more understanding and concern for patients."

Direct results

Many course topics sprang from recent House of Delegates resolutions calling for the society to educate its members on specific medico-social issues. Others were committee recommendations aimed at problems identified at the grassroots level.

One course, "Child Abuse: How to Make the System Work for Your Patient," was a direct result of MSMS committee action. Resolution 7, 1982, resolved that the Council should investigate changes needed to improve protective services for abused children. A committee was formed to study the problem, and it was that committee that suggested a course be presented to educate members.

Resolution 28 of the same year called upon members to inform themselves, their colleagues, and the general public about the medical consequences of nuclear war. Hence, MSMS offers "An Overview of the Human Health Effects of Nuclear Weapons."

"Medically-Related Communication Disorders" had its impetus in Resolution 52, 1982. In it, the MSMS Medical Student Section called for physician training in sign language to improve care to the deaf. The Annual Scientific Meeting Planning Committee expanded on the subject to include other kinds of communication problems, and expects that participants will come away with tools to better treat a variety of affected patients.

The MSMS Program to Assist Impaired Physicians will sponsor "Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal," designed to help the physician recognize and treat the dependent patient. Along similar lines, "Identification and Treatment of Substance-Abusing Women" is scheduled to enable physicians to learn why drugs become a problem for so many women, and how they can best motivate patients to seek further help. "Helping the Troubled Employee: The Role of Physicians in Industry," will propose that physicians and industry work together to improve the quality of care to chronic substance abusers in the work setting.

The MSMS Committee on Aging and the Michigan Health Council have combined resources in order to present "Adding Life to Years: Meeting the Needs of the Aged." The course will provide an overview of the medical, social and psychological needs of this special and growing population.

Other 'high touch' topics to be covered include: anorexia nervosa, a psychological as well as biological ailment on the rise in our society; marijuana's medical, legal and social implications; troubled adolescents; home health care for infants and children; and the ethical issues in ambulatory care.

MSMS encourages physicians to participate in these sessions as part of their continuing commitment to preserve the 'high touch' approach to medicine.

Course schedule

Here's your 'high touch' course schedule:

Tuesday morning

"Child Abuse: How to make the system work for your patient"

"Helping the Troubled Employee: The Role of Physicians in Industry"

"Medically-Related Communication Disorders: The Physician's Role"

Tuesday afternoon

"Adding Life to Years: Meeting the Needs of the Aged"

"An Overview of the Human Health Effects of Nuclear Weapons"

"Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal"

Wednesday morning

"A Comprehensive Review of Anorexia Nervosa"

"Identification and Treatment of Substance-Abusing Women"

"Marijuana — Its Medical, Legal and Social Implications"

Wednesday afternoon

"Ethical Issues in Ambulatory Care"

"The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression and Drug Abuse"

Thursday morning

"Home Health Care Programs: Pediatrics and Adults"

uch

Here are Annual Scientific Meeting course directors:

Tuesday, November 15
Morning courses

Robert K. Orr, DO
"Basic Cardiac Life Support"
(Repeated on Wednesday and Thursday mornings)

Harold Perry, MD
"Cancer Patient Management in the 1980s: The Role of Radiation Oncology"

Barbara Meyer Lucas, MD
Brooker L. Masters, MD
"Child Abuse: How to Make the System Work for Your Patient"

This course will present a multidisciplinary approach to handling child abuse, with representatives from the police, protective services and the legal establishment to help doctors use the system in the most beneficial way for their patients.

Dorothy M. Kahkonen, MD
"Diabetes — Current Management and New Developments"

Humulin (biosynthetic human insulin) produced by techniques using recombinant DNA is an exciting development in the treatment of diabetes. We will explore this topic, as well as the Diabetes Control and Complications Trial sponsored by the NIH and designed to determine whether good control prevents complications and can be achieved safely.

Beverly J. Fauman, MD
"Emergency Psychiatry"

Although psychiatric emergencies constitute a small percentage of cases, they consume a significant amount of time when they arise. Specific tips from our national policy-setting speakers will help reduce physicians' time and anxiety in handling these difficult and frightening problems.

Kamran S. Moghissi, MD
"Evaluation and Management of Infertile Couples"

Attendees will learn newer techniques of clinical and laboratory assessment of infertility problems in the office, and advances in operative procedures to improve fertility.

Bertram Schnitzer, MD
"Flow Cytometry: Clinical Application"

Flow cytometry is a technology of the future which will help the physician make more precise diagnoses. Attendees will learn about monoclonal antibodies and their application in the diagnosis of leukemias, lymphomas, and immunodeficiency disorders and in following patients with renal transplantation.

Jack E. Benkert, MD
"Helping the Troubled Employee: The Role of Physicians in Industry"

This course will uncover new discoveries regarding use of an employer as a support mechanism for a physician's private practice activities.

Myron Laban, MD
Michael I. Rolnick, PhD
"Medically-Related Communication Impairments: The Physician's Role"

This first MSMS course in the management of speech, language and voice disorders will present the latest on specialized rehabilitative care, techniques for assessing disorders, including the use of computers.

Alexander

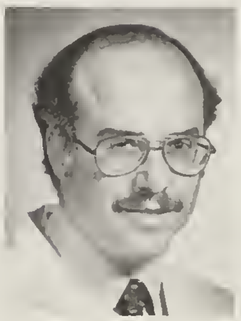
Allaben

Bateman

Bauer

Benkert

Boxer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Breiner

Bryant

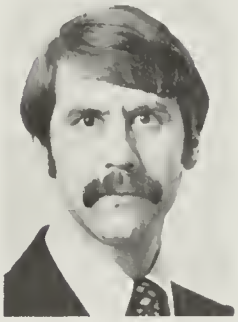
Cerny

Ditmars

Flory

Gelehrter

Gilmore

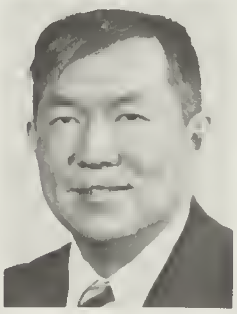


Grambau

Greenbaum

Hartline

Henry



Ho

Honet

Hunt

Joynt

Kahkonen

Kelsch

Robert E.M. Ho, MD
"Traumatic Injuries to the Head, Spine and Peripheral Nerves"

This course offers a comprehensive practical review of brain, spinal cord, and peripheral nerve injuries in a single block. Completion of this course will enable the physician to diagnose and treat common injuries.

Tuesday, November 15 Afternoon courses

William T. Bateman, MD
"Adding Life to Years: Meeting the Needs of the Aged"

E.V.D. Perrin, MD
"An Overview of the Human Health Effects of Nuclear Weapons"

This course will present a factual statement of the effects of blast, thermal injury, acute and chronic radiation, to help the physician and patients to understand the medical consequences of nuclear conflict.

Gaylord D. Alexander, MD
"Chronic Drug Therapy in the Surgical Patient"

Patients coming to surgery frequently are on medications which affect intra- and post-operative courses. These include calcium blockers, beta blockers, diabetic drugs, antihypertensives and psychotherapeutic drugs. Attendees will learn which to continue, which to discontinue and which to increase.

John L. LaFerla, MD
"Diagnosis and Management of Pelvic Pain"

David R. Rovner, MD
"High Quality Care with DRGs"

Thomas Gelehrter, MD
"Medical Genetics for the Practicing Physician"

The application of simple genetic principles in selected families offers the physician a unique opportunity to define individuals at high risk for a particular disease, and by early diagnosis and intervention, to prevent a serious clinical illness.

R.F. Smith, MD
"Medical Management of Acute Alcohol Withdrawal"

Alcoholism has undergone a major educational revolution in the past 20 years, and now is recognized as a treatable disease. It is now possible to help the alcoholic and the physician know better how to handle this disease.

Dennis L. Murray, MD
"Pediatric Immunology/Infectious Diseases — New Concepts and Treatment Modalities"

This course will help the physician recognize the child with immunodeficiency, handle the information overload regarding all the new cephalosporin antibiotics and use new texts available to help differentiate viral and bacterial infection.

David S. Greenbaum, MD
"Some Burning Issues in Gastroenterology"

Wednesday, Nov. 16 Morning courses

Elliot D. Luby, MD
"A Comprehensive Review of Anorexia Nervosa"

Anorexia nervosa has become a problem of growing concern for the internist, pediatrician and family practitioner. The disorder is increasing in frequency. This course will help every physician attending be more aware of its signs, symptoms and treatment approaches.

Joseph C. Honet, MD
"Arm Pain and Dysfunction: Diagnosis and Management"

A multidisciplinary team will provide information, using television monitoring and extensive handouts, to help the primary care physician examine, diagnose and treat patients who complain of upper arm pain or disability.

Joe D. Morris, MD
"Esophageal Disorders for the General Physician"

Sean B. Peppard, MD
"Evaluation and Treatment of the Dizzy Patient"

Suzanne R. Parker, MD
"Identification and Treatment of Substance-Abusing Women"

George L. Royer, Jr., MD
"Marijuana — Its Medical, Legal and Social Implications"

Geoffrey R. Grambau, MD
"New Developments and Old Myths about Hyperbaric Oxygen Therapy"

HBO therapy, available on a regular basis at only two Michigan institutions, is the primary mode of therapy or a useful adjunct in selected patients with acute, chronic or catastrophic illness. The physician will learn to identify which patients would benefit from this relatively new modality.

Robert D. Allaben, MD
"Surgery for the Morbidly Obese"

Physicians attending this session will learn which patients are candidates for surgery, the types of surgery indicated and the long-term results. MDs then will be able to answer their patients' questions and to refer them to the proper facilities.

Wednesday, Nov. 16 Afternoon courses

Clyde R. Flory, MD
"Allergy Update: Asthma, Foods and Stinging Insects"

Attendees will learn the role of additives, challenge tests and immunotherapy in asthma; will learn which food allergy tests are controversial and why, and will learn which childhood sting reactions require venom immunotherapy.

Joseph C. Cerny, MD
"Current Management of Kidney Stone Disease"

Andrew D. Hunt, Jr., MD
"Ethical Issues in Ambulatory Care"

Gregory L. Henry, MD
"Neurological Emergencies"

The attendee will learn to reduce time doing a neurological examination by improving techniques and by gaining a better understanding of the crania.

Richard LaMont, MD
"Pediatric Orthopaedics for Family Practitioners"

B.B. Gilmore, Jr., MD
"Pediatric Otolaryngology Problems"

Enthusiastic academic practitioners will teach and learn from the physicians attending this course, which will provide practical "how-to" information on common and uncommon ear/nose/throat disorders.

Raymond B. Bauer, MD
"Recent Advances in Neurology"

This course should allay some of the apprehension of the practitioner in diagnosing and treating Parkinson's Disease, movement disorders, myasthenia gravis and epilepsy. Faculty will discuss plasmaspheresis, "drug holidays," the "on-off phenomenon" and an animal model now available to help evaluate treatment for Parkinson's.

Sander J. Breiner, MD
"The Adolescent Who Doesn't Finish Any Task"

This topic should open a diagnostic and therapeutic door in the non-psychiatric/general medical practice to help solve common problems in family and community settings. Physicians will learn the differential diagnosis of task incompletion, drug use, psychosis, depression and school/work inhibition.

Neil A. Swanson, MD
"What's New in the Management of Cutaneous Tumors"

Thursday, Nov. 17 Morning courses

Robert F. Wilson, MD
"Controversies and Advances in Trauma"

Conrad E. Nagle, MD
"Gastrointestinal Scintigraphy"

Purpose of the course is to help referring physicians better select gastrointestinal imaging procedures in evaluating patients with suspected or known hepatobiliary disorders, lower gastrointestinal bleeding and gastric emptying disorders.

John V. Hartline, MD
"Home Health Care for Pediatric and Adult Patients"

In light of recent federal interest in home health care and the overall interest in rising health care costs, thorough exploration of this alternative should be worthwhile to the physician who deals with patients with long-term illness.

George L. Royer, Jr., MD
"Hypertension — Current Therapeutic Update"

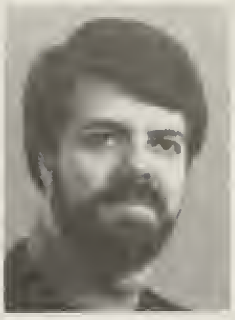
Eugene Rontal, MD
"The Medical Use of Lasers"

This course will acquaint the physicians with the actual medical uses of lasers to enable them to answer the public's questions.

Laurence A. Boxer, MD
"Advances in Pediatric Hematology/Oncology"

Practicing physicians will become familiar with some of the exciting advances in use of immunological aids and the diagnosis and potential treatment of patients with acute

LaBan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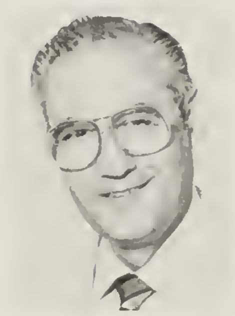
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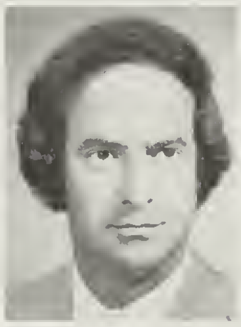
Perry


Rolnick

Rontal

Rovner

Royer

Schnitzer

Smith

Swanson

Weiss

Wilson

leukemias. The course also will discuss chemotherapy in management of patients with lymphomas and leukemias.

Donald M. Ditmars, Jr., MD
"Control of Scars"

The techniques of scar control will be reviewed for surgeons. The speaker is the author of a definitive book on the subject.

Frederick W. Bryant, MD
"Vision"

Thursday, Nov. 17 Afternoon courses

William J. Byrne, MD
"Common Gastrointestinal Problems in Children: Diagnosis and Management"

R.L. Joynt, MD
"Conservative Treatment of Low Back Pain"

Attendees will gain an understanding of the basic anatomy and pathology of the lumbo-sacral spine and an improved ability to evaluate and treat this most common problem encountered by the physician.

Robert L. Bree, MD
"Diagnostic and Therapeutic Interventional Radiology"

The multiple forms of interventional radiologic techniques will be combined in one three-hour session, emphasizing their availability, accuracy, success rates and potential complications. Plenty of time will be allowed for questions and comments. The course is designed to update the practicing physician.

Frederick W. Bryant, MD
"Ophthalmic Outpatient Procedures"

Robert C. Kelsch, MD
"Selected Topics in Pediatric Ambulatory Medicine"

Joseph J. Weiss, MD
"Treatment of Arthritis"

Physicians experienced in the field will describe fundamentals in therapy for rheumatoid arthritis, osteoporosis and vasculitis, to help the generalist make appropriate decisions.

Donald M. Ditmars, Jr., MD
"Unique Techniques in Plastic Surgery"

Designed for the specialist, this course will explore relatively unknown procedures and will repeat the previous year's "new ideas" session.

W. Patrick Mazier, MD
"Update on Common Anorectal Problems"

This course will provide helpful diagnostic and therapeutic hints.

Neil A. Swanson, MD
"What's New in Dermatology"

The experts will review recent advances and therapies, including the use of Accutane, so that the physician can discuss the recent popular literature with patients.

Register for courses on page 515

Outstanding speakers on tap for Annual Scientific Meeting

Speakers scheduled for the 1983 MSMS Annual Scientific Meeting as usual are among the finest to be found in their areas of expertise.

Course directors work hard to bring in the most interesting, authoritative leaders to share their knowledge from the lecture podium and then on an informal basis during question and answer periods.

Plenty of time is planned by most course directors for comments and evaluations at the close of the talks. Evaluations then are used to better plan and refine coming annual scientific meetings, so that each year's offerings are more finely tuned.

In some cases speakers for the 1983 event come from out of state, offering their unique information and perspectives to the discussion. Some of the out of state speakers this year include:

Donald G. Vidt, MD, head, clinical section, Department of Hypertension, Cleveland Clinic Foundation, Cleveland. Doctor Vidt will discuss "New Drugs on the Horizon" in the Thursday morning course, "Hypertension — Current Therapeutic Update."

Robert Archer, MD, research associate, central nervous system research, Eli Lilly and Company, Indianapolis. Doctor Archer will discuss "The Place of Synthetic Cannabinoids in Medical Practice," in the Wednesday morning course, "Marijuana: Its Medical, Legal and Social Implications."

The author of a book on scar control, **Albert F. Borges, MD**, Falls Church, VA, will headline the Thursday morning course on that subject presented by the Michigan Academy of Plastic Surgeons. Doctor Borges is in private practice.

Philip Bailin, MD, professor and chairman of the Department of Dermatology, Cleveland Clinic, Cleveland, will take part in one of the courses on the new technology in medicine. His topic will be "Laser Surgery: Theory and Applications." He will speak during the Wednesday afternoon session, "What's New in the Management of Cutaneous Tumors."

Sumer Verma, MD, MSU associate professor of psychiatry and medicine, will return from a sabbatical at Cambridge University to discuss "Geriatric Depression" as part of the Tuesday afternoon course, "Adding Life to Years: Meeting the Needs of the Aged."

At-a-glance schedule of ASM special events

Monday, Nov. 14

8:00 PM	MSMS/PSG Financial Planning Seminar, for physicians and spouses

Tuesday, Nov. 15

7:30 AM	Exhibit Hall Open
11:45 AM	Deli luncheon, exhibit hall
8:00 PM	MSMS/PSG Financial Planning Seminar, for physicians and spouses
8:00 PM	Michigan Health Council "Wellness Workshop" for physicians and spouses

Wednesday, Nov. 16

7:30 AM	Exhibit Hall open
11:45 AM	Deli luncheon, exhibit hall
11:45 AM	Luncheon/Speaker Michigan Psychiatric Society Women's Issues Committee
5:30 PM	Meeting, Reception and Dinner Michigan Society of General Surgeons
6:00 PM	Reception and Dinner Michigan Branch, American Urological Association
	Reception Wayne State University Medical Alumni
	Reception and Dinner Michigan Otolaryngological Society

Thursday, Nov. 17

7:30 AM	Exhibit Hall open
11:45 AM	Deli luncheon, exhibit hall
Noon	Luncheon Meeting Foreign Medical Graduate Psychiatrists
5:30 PM	Reception and Dinner Michigan Ophthalmological Society
6:30 PM	Reception and Dinner Michigan Society of Colon and Rectal Surgeons

Here are 65 good reasons to visit ASM exhibit hall

There are 65 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn.

The trained professional representatives of 65 firms will be awaiting the opportunity to discuss with physicians the details of their products and services in a relaxed atmosphere, where there are:

No patients awaiting care.
No emergencies.
No office management problems.

The exhibit hall is an important part of the Annual Scientific Meeting, and is the site of registration for all courses and special events. In addition, the deli luncheons offered by MSMS to all Annual Scientific Meeting participants, and after-hours beer breaks are staged in the exhibit area.

Early in the morning before courses begin, during breaks, at the lunch hour and after the afternoon courses end, physicians attending the meeting have the opportunity to browse the exhibits to gather further information in a relaxed, selective manner.

To help MSMS members plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

Pharmaceuticals

Generic vs. brand name, contraindications, new products . . .discuss these questions with:

Adria Laboratories, Inc.
Ayerst Laboratories
Boehringer Ingelheim
Bristol Laboratories
Dista Products Company
Eli Lilly and Company
Hoechst-Roussel Pharmaceuticals
Parke-Davis Company
Reed and Carnrick
Ross Laboratories
Searle Laboratories
Smith Kline and French Laboratories
Smith Kline and French Cardiovasculars
Syntex Laboratories
The Upjohn Company

In-office equipment and support

Diagnosis and ability to care for your patients in-office require available, dependable equipment.

City Xray Company
Cryomedics
E & M Medical Systems
Firestone X-ray Corp.
Tom Herbst and Associates
Michigan Bell
Michigan Scanning Services
ProMed, Inc.
Vascular Diagnostic Instruments

Clinical laboratories

Compare services of your current clinical laboratory with those of:

Advance Medical and Research
Allied Integrated Diagnostic Services
Dearborn Clinical Lab.
MetPath Inc.
Oakland Diagnostic Laboratory
Quality Clinical Laboratories, Inc.
WMPC Toxicology Laboratory

Patient home care

Send your patients home with information regarding equipment and supplies to assure continued compliance with your home care regimen.

American Hospital Equipment Company
American Orthopedic Service
AminoMed Inc.
Gerber Products Company
Home Oxygen Medical Equipment
Ross Laboratories
White and White

Computers/computer services

Bennethum Computer Systems
Comedco, Inc.
Computer Terminal Services, Inc.
Data-Med Corporation
Engram Medical Management Systems
GTE Telenet Communications Corporation
Medical Administrative Computer Services
Medpac/Computer Methods Corporation
Michigan Medical Services
Professional Billing Inc.
Rollins Medical/Dental Systems
T/Com Computerized Insurance Billing Systems

Education resources

Milex of Michigan
W.B. Saunders

Protection

Blue Cross Blue Shield
First Heritage Corporation
The Medical Protective Company
Michigan Physicians Mutual Liability Company
Physician Insurance Company of Michigan
Stratton-Cheeseman and Associates, Inc.

Career alternatives

U.S. Air Force
U.S. Army

Other exhibitors

Hack Shoe Company
Health Care News
McCullagh Leasing — car leasing
Metro Vehicle Consultants — car leasing
Michigan Ophthalmological Society

PLEASE SEND ENTIRE PAGE WITH CHECK

1983 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

*All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.

TUESDAY MORNING, NOV. 15

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Cancer Patient Management in the 1980s: The Role of Radiation Oncology
____ Child Abuse: How to Make the System Work for Your Patient
____ Diabetes — Current Management and New Developments
____ Emergency Psychiatry for the Non-Psychiatrist
____ Evaluation and Management of Infertile Couples
____ Flow Cytometry: Clinical Application
____ Helping the Troubled Employee: The Role of Physicians and Industry
____ Medically-Related Communications Impairments: The Physician's Role
____ Traumatic Injuries to the Head, Spine, and Peripheral Nerves

TUESDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Adding Life to Years: Meeting the Needs of the Aged
____ An Overview of the Human Health Effects of Nuclear Weapons
____ Chronic Drug Therapy and the Surgical Patient
____ Diagnosis and Management of Pelvic Pain
____ High Quality Care With DRGs
____ Medical Genetics for the Practicing Physician
____ Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal
____ Pediatric Immunology/Infectious Diseases: New Concepts and Treatment Modalities
____ Some Burning Issues in Gastroenterology

WEDNESDAY MORNING, NOV. 16

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ A Comprehensive Review of Anorexia Nervosa
____ Arm Pain and Dysfunction: Diagnosis and Management
____ Basic Cardiac Life Support
____ Esophageal Disorders for the General Physician
____ Evaluation and Treatment of the Dizzy Patient
____ Identification and Treatment of Chemically Dependent Women
____ Marijuana — Its Medical, Legal, and Social Implications
____ New Developments and Old Myths About Hyperbaric Oxygen Therapy
____ Surgery for the Morbidly Obese

WEDNESDAY AFTERNOON, NOV. 16

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Allergy Update: Asthma, Foods, and Stinging Insects
____ Current Management of Kidney Stone Disease
____ Ethical Issues in Ambulatory Care
____ Neurological Emergencies — An Approach
____ Pediatric Orthopaedics for Family Practitioners
____ Pediatric Otolaryngology
____ Recent Advances in Neurology
____ The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression and Drug Abuse
* ____ What's New in the Management of Cutaneous Tumors

THURSDAY MORNING, NOV. 17

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Controversies and Advances in Trauma
____ Gastrointestinal Scintigraphy (Imaging)
____ Home Health Care Programs: Pediatrics and Adults
____ Hypertension — Current Therapeutic Update
* ____ Medical Use of Lasers
____ Recent Advances in Pediatric Hematology
____ Scar Control
____ Vision

THURSDAY AFTERNOON, NOV. 17

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Common Gastrointestinal Problems in Children: Diagnosis and Management
____ Conservative Treatment of Low Back Pain
____ Diagnostic and Therapeutic Interventional Radiology
* ____ Ophthalmic Outpatient Procedures
____ Selected Topics in Pediatric Ambulatory Medicine
____ Treatment of Arthritis
* ____ Unique Techniques in Plastic Surgery
____ Update on Common Anorectal Problems
____ What's New in Dermatology

The half-day courses will provide three hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/24/83 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, (313) 593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

Name ____________________
(please print) (first) (initial) (last)

Street ____________________

City, State ____________________ ZIP ____________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ____________ Other ____

Tuition Schedule for Courses:

MSMS members: $6 per credit hour, or $18 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $12 per credit hour, or $36 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ________ Wednesday lunch ________ Thursday lunch ________
- Indicate total number of half-day courses:

	____ x $18 (members)	$ ________
	____ x $ 9 (retired)	$ ________
	____ x $36 (non-members)	$ ________
	____ x $ 5 (residents)	$ ________

- Please enroll me in the MSMS/PSG seminars, being held from 8-10 p.m. (Physicians' guests are free.)

Mon. 11/14 "Investment Alternatives for the '80s":	____ ($10 fee)	$ ________
Tue. 11/15 "Retirement Plans: Living with TEFRA":	____ ($10 fee)	$ ________
	TOTAL	$ ________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

For ASM and other meeting planners—here's how to treat a speaker

By Jean Spencer Felton, MD
Irvine, Calif.

This article first appeared in the section, "A Piece of My Mind," *Journal of the American Medical Association,* March 25, 1983. It seems appropriate for printing in this issue, which highlights the courses and speakers of the 1983 MSMS Annual Scientific Meeting. Physicians planning meetings could well use this author's suggestions.

Since continuing medical education (CME), in any of its many formats, has been mandated for many physicians in their retention of board certification or licensure, most medical centers — university or hospital based — have made lectures by their own staff members or by visiting faculty available to their staffs.

Having been closely affixed to many lecterns in over four decades of addressing medical and mixed audiences, I have experienced certain disconcerting occurrences that could easily have been averted.

While physicians giving public addresses often enjoy the sharing of knowledge, teaching can be carried out most effectively only after there has been adequate preparation, including preliminary discussion with the person who will introduce the speaker.

Avoid glitches

To avoid some of the glitches that often arise, I suggest the following checklist for caring for a visiting speaker:

1. Invite the prospective speaker initially by telephone to establish a date and time convenient to both the guest and the institution.

2. Send a letter on the host organization letterhead with address, confirming the arrangements as to (1) place (building), (2) location (room), (3) date, (4) inclusive time, (5) concurrence (or not) with a meal (before, during, or on conclusion of breakfast, lunch, or dinner), (6) title of presentation, (7) name, address, and telephone number of contact person, and (8) a request for a brief curriculum vitae. The letter should be accompanied by a map that shows the relationship of the facility to the freeway network or adjacent streets.

3. Include details such as (1) closest parking area, (2) any tokens that will be supplied or validation of parking tickets that will be accomplished and by whom, when, and where, (3) audiovisual needs (house operator, speaker-controlled projector, or mandatory union operator, type of projector, type of microphone [fixed or wandering-neck]), (4) number and type of persons in expected audience, and (5) expectations of handout material.

4. Indicate whether an honorarium will be offered and the amount, whether one's social security number will be required, and what expenses will be reimbursed.

5. On arrival, meet the speaker at the designated entrance, provide escort to the conference room, and ask him or her to check the lectern, lights, microphone, projector, and the sightlines in the area. If there are handout materials, offer to pass these out at a time suggested by the speaker.

Show sense

6. Introduce the speaker to the Chair of the day to ensure that the descriptive biographic material will be accurate. Have the Chair show a sense of having seen the curriculum vitae prior to 5 milliseconds before ascending the dais.

7. If the meeting includes a meal, and the speaker has not been able to eat before the presentation, offer the meal after the talk.

8. Accompany the speaker to the exit door closest to the parking area.

9. Send an honest letter of appreciation.

10. Do not arrange such an address to follow a business meeting, because such a function often reduces available time to below a reasonable minimum.

With this system of the care and feeding of speakers, CME can be a worthwhile experience in learning, and not just an opportunity for the hospital staff member to gain a free meal or a chance to read the morning newspaper. Speakers have feelings too.

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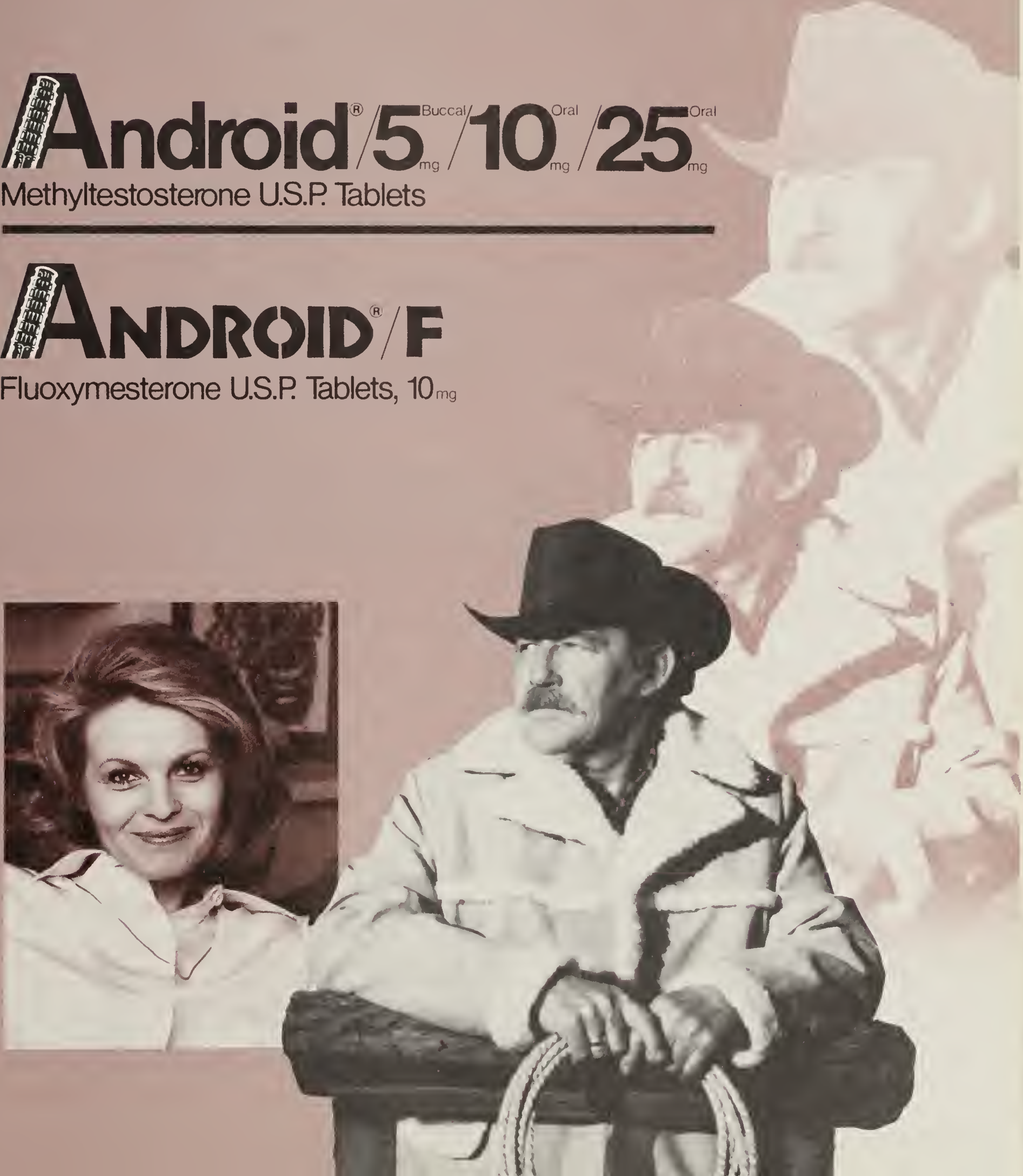

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8216 Deerwood Rd.
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More new members on page 522

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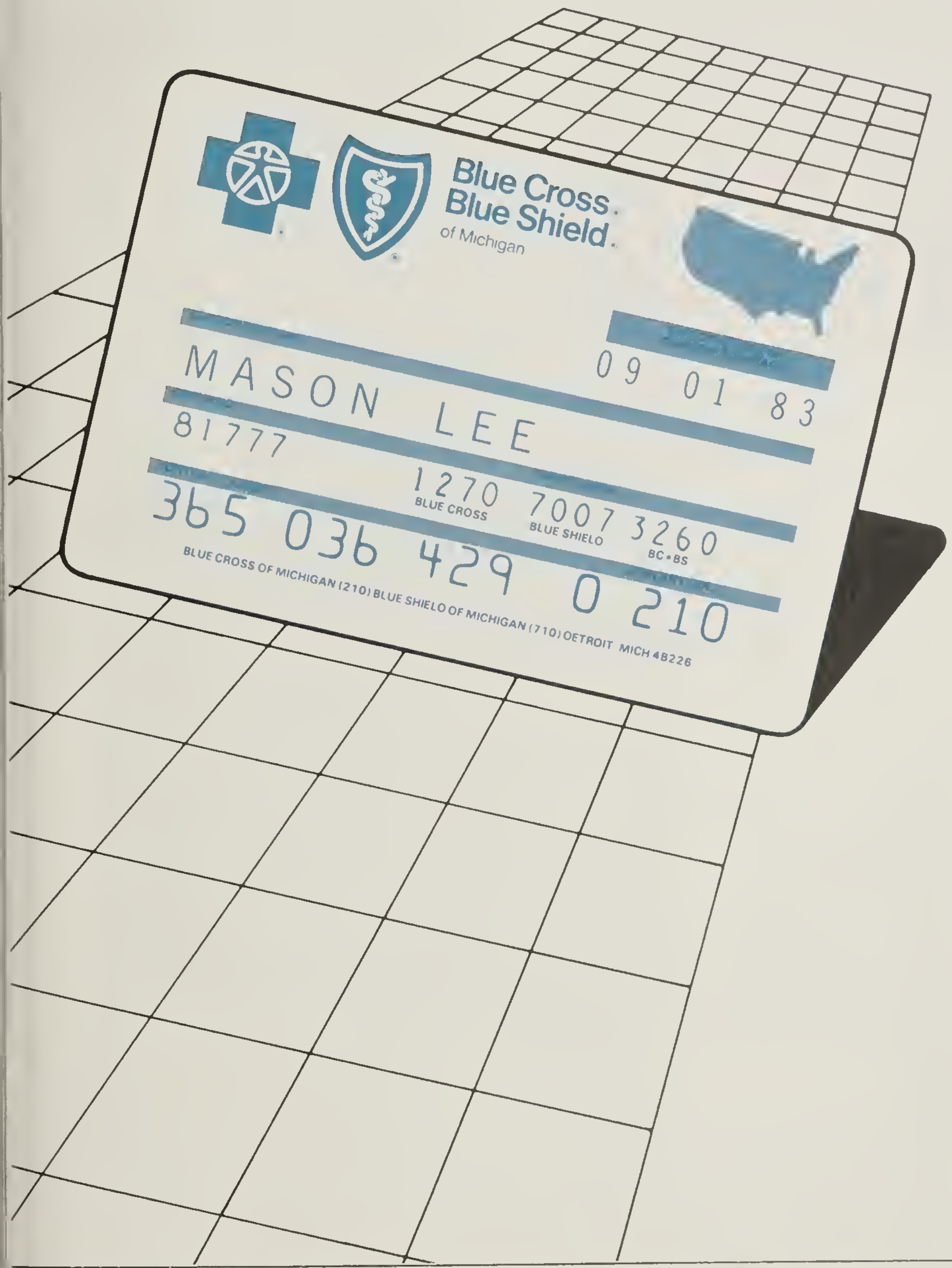

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Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan . . . a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $ 500 one person
$1,000 family

Dimension III for employees:
Deductible — $100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too?
For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

IT'S GOOD TO BELONG.

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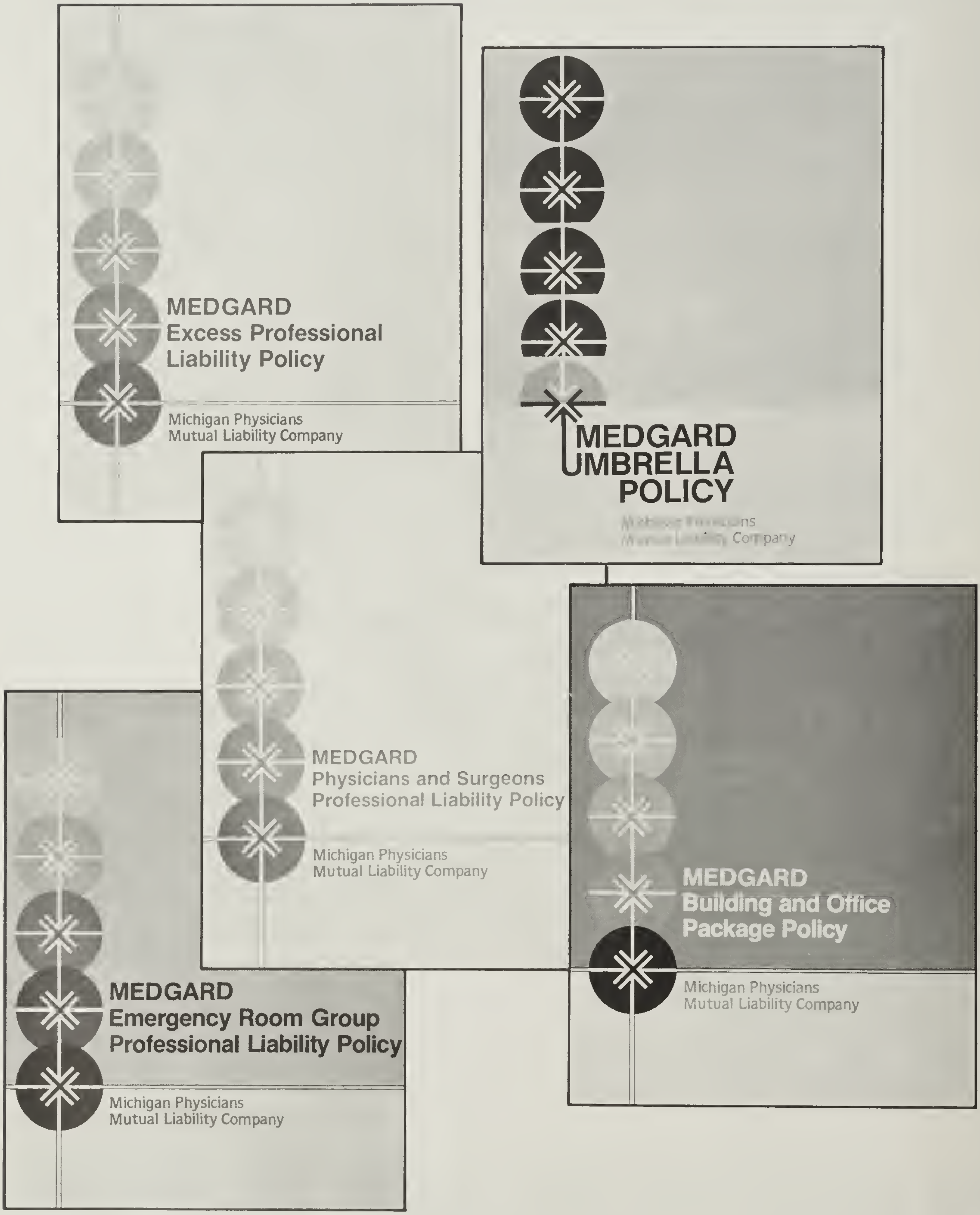
of Michigan

WHAT YOU SEE.



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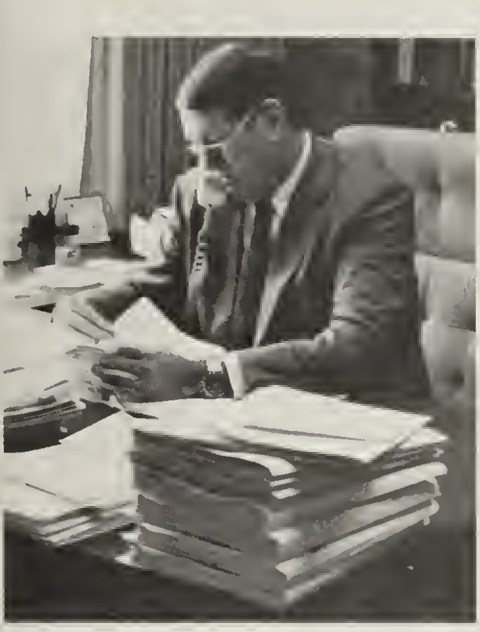
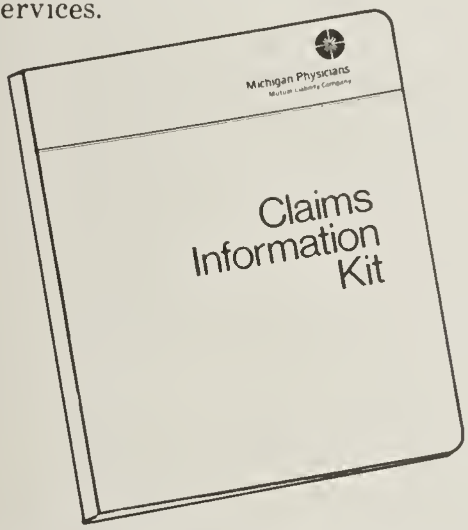
AND WHAT YOU GET.



Service. Claims service is what you buy a professional liability policy for in the first place. Our policies are backed by the most experienced professional liability claims staff in Michigan. Our claims representatives return your phone calls and keep you informed of the progress of any claim in which you may be involved. These professionals and the excellent defense attorneys assigned to represent our policyholders have helped Michigan Physicians build our excellent reputation for claims services.



Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our inhouse computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

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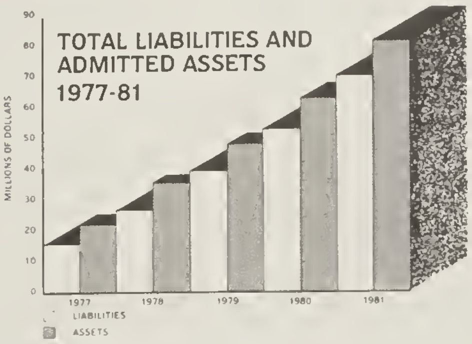

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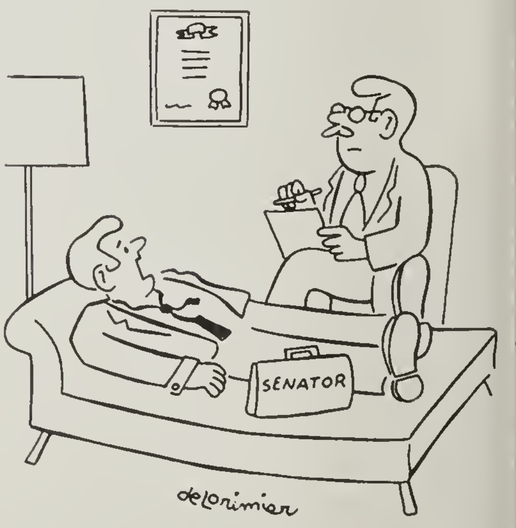

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I have cancer — here's what you can do

By Wendy Bergren
Lafayette, CA

The following article was written as the author fought a malignancy diagnosed shortly after she became a mother for the third time. Though friends tried their best to help, most, she said, "didn't know how to cope, or how to assist someone who was seriously ill with cancer." Mrs. Bergren's suggestions would apply to anyone disabled and trying to carry out family responsibilities. Her article first appeared in "Focus on the Family with Doctor James Dobson," Vol. 6, No. 10, November 1982. A one-hour tape also is available from the Focus on the Family organization, PO Box 500, Arcadia, CA 91006. Perhaps MSMS members will share it with their patients and their families.

I am a married young woman struggling to beat cancer. My husband and I have three children: a baby, a preschooler and a first grader. Since I am severely ill, we depend on our friends for survival. Over the months, so many have asked, "What can I do to help?" Here are some ideas.

1. Cook a dinner for my family, but offer a choice of two courses. One week we got tuna noodle casserole four nights in a row from well-meaning friends! Also, bring the food in disposable containers or marked pots. If I can't return your casserole, I will cry at my powerlessness and confusion.

2. Bake homemade cookies or brownies and bring them frozen so I can have the delight of sending off fresh goodies in a lunchbox the next morning. This will give me the fun of feeling like a mama.

3. Make your offer specific. Say,"I want to come over Monday at 3:00 to bake cookies or clean your pantry shelf, or whatever." If you say, "Call me any time for anything," I won't know what you want to do, or when you are free, so I probably won't ask.

4. Offer to babysit — even if my husband and I stay home. This gives us the freedom of a private adult life in a place my illness can cope with.

5. Help with holidays, birthdays, and anniversaries. Ask if there are any special gifts or cards or wrapping papers you could pick up for me. How many times I have wanted to give my husband a special thank you card or put up a holiday decoration, but have been unable!

6. Help my children attend birthday parties by bringing some prewrapped children's birthday party gifts to our home for future use.

7. Call before you visit, but drop by for 20 minutes when you can. Don't assume sickness requires rest at the expense of communication. (Loneliness is the greatest interrupter of sleep.) A spur-of-the-moment visit can be dissuaded without hurt feelings. But if I plan and look ahead to your visit for weeks and then you cancel, I will feel more ill and more debilitated than before.

8. Ask me who you know that I might like to see, and bring them by. Often I am too shy to approach a friend of my own. My whole life consists of asking favors, and I may just be too tired to make social requests, too.

9. Take snapshots of my children over the months. This gives me a feeling that there are permanent records of the temporary happenings I must miss.

10. Offer to run two meaningless errands a week for our family. The small stuff — hair ribbons, or cologne or clean suits — fall by the wayside otherwise.

11. Allow me to feel sad or to prepare for the worst. One of the most difficult problems of serious illness is that everyone wants to encourage the patient. But sometimes, having a good cry with a friend who allows it will let the tension escape — as when a dam is broken. I have one friend who lets me call her when I feel sad or lonely or ready to give up — and by the time I finish dialing her number and hear her answer "Hello," the fear is gone. Sometimes, the greater part of the cure is the release of fear.

12. Even if the joke is terrible, tell it! Share your humor. Bring *Reader's Digest* and read aloud. De-

Continued on page 526

scribe what is funny out there. It may not tickle my ribs today, but tomorrow I may relish it! Speak to the part of me that is more alive than dead, for that is the real me.

13. Touch me. The isolation of being an invalid makes the power of love sweeter.

14. Offer to watch TV with me some afternoon when an old movie is on. Bring a book or magazine in case I fall asleep. This gives me the satisfaction of providing enjoyable company without the responsibility of entertaining you.

15. Say the word cancer around me and talk about the *real life* you are living. This helps me feel less like an untouchable and more like I am still involved with the world of normalcy. One of the hardest things for me as an invalid is the problem of conversation with my husband. If you don't talk to me about the life outside, I am left with only illness and TV to talk about with him, and this is hard.

16. Tell me how great I look considering what I'm going through. I know I look sick, but I still need to feel honestly attractive.

17. Encourage your husband to come over to visit my husband in the evenings. One of the greatest gifts I have is my husband; yet my illness has eliminated many of his pleasures. How happy I am when I hear him laughing with a friend in his shop or cheering Monday night football and popping popcorn with a pal!

18. Pray for me and say you are doing so. The fact that you have faith gives me faith.

19. Talk to me of the future. Next week, next year, 10 or 20 years! The power of planning is incredible. Talk to me of my baby's senior graduation, and I can get through the next week. Bring by travel folders for my silver anniversary trip, or discuss possible hairstyles for when my hair grows back in. If you look ahead, I can too.

20. Remind me of the abundant life that awaits me and is promised. But also recall that there is comfort to be had here and now, in the midst of my illness. The Bible tells us that Christ is the healer, the comforter, the understanding fellow-sufferer. He brings cure and respite, not illness; and he holds me in the cup of his hand. Offer to be here with me now, as he is and will be with me forever. The fact that you could care so much in this moment tells me how much he cares for me in all moments.

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MSMS supports AMA chelation position

The MSMS Board of Directors at its midsummer meeting in July endorsed the AMA position on chelation therapy for atherosclerotic disease, on the recommendation of the board's reference committee on Scientific and Educational Affairs.

The MSMS Scientific and Educational Affairs Committee received the following interpretation of the AMA's position from the AMA Division of Scientific Policy. This is the AMA stand endorsed by the MSMS Board:

"There is consensus among all respondents that chelation therapy with ethylenediamine tetraacetic acid or its sodium salt is not an established treatment for atherosclerotic vascular disease.

"The original thesis that repeated intravenous infusions of the chelating agent, EDTA disodium, was of benefit to patients with coronary artery disease, as manifested by the anginal syndrome, has not been established in any well-designed, controlled trial. Although some uncontrolled studies claim positive benefits, others have shown no significant effects from such therapy.

"There is no supporting evidence that it has any significant effect upon the atherosclerotic plague. Furthermore, the safety of using EDTA, especially in patients with coronary artery disease, is questionable. Chelation of plasma calcium will decrease the levels of ionized calcium and may result in tetany, cardiac arrhythmias, convulsions, and respiratory arrest. It can cause renal tubular necrosis and renal failure, permanent renal damage, bone marrow depression and prolongation of the prothrombin time.

"The U.S. Department of Health and Human Services released a report on 'EDTA Chelation Therapy for Atherosclerosis' in 1981 (H.R.S.T. Assessment Report Series: Vol. 1., No. 18). It noted that chelation for this indication is controversial, that there is no accepted rationale for its effectiveness, and its safety is questioned. *The Medical Letter*, in 1982, reviewed the experience over 20 years and concluded that 'There is no acceptable evidence that chelation therapy with EDTA is effective in the treatment of atherosclerosis and the adverse effects of the drugs can be lethal.'

"In summary, there is general agreement that chelation therapy has not been established as an acceptable treatment for coronary or other arterial atherosclerosis."

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Sale of a medical practice — a new way to set a price

By J. Kingsley Cotton III
Bloomfield Hills

Despite wistful longing for simpler days when business could be conducted with a smile and a handshake, transferring ownership of a medical practice today is a complex transaction.

For most physicians, even the seemingly simple task of setting the sale price is confounding. In fact, of all the dilemmas that buyer and seller encounter, the most frequent and most basic is valuing and pricing the practice. While both parties may agree that they want only to set a "fair" price, reasonable minds can differ as to what constitutes "fair."

The author is with the legal firm of Denison, Bartush and Cotton.

No price

One way to alleviate the problem is to not set a purchase price at all.

It used to be that when the kindly general practitioner was ready to hang up his stethoscope, he would put in a call to the intern program at his alma mater in hopes of finding someone willing to take over the practice. Usually an eager graduate came on board, happy to apprentice for awhile at a modest salary.

Eventually, the two would agree on a price for the office furniture and equipment and the white-haired one would phase himself out. The new practitioner would pay for the hard assets over a few years and would agree to assume the lease and any other liabilities. The senior physician, content that his patients liked their new doctor, would leave with his accounts receivable and perhaps some arbitrarily determined payment for goodwill.

Alas, those informal arrangements have gone the way of rabbit tests and sanitariums. The increasing use of attorneys, accountants and financial advisors in the transfer of professional practices parallels the growth of specialties and subspecialties in medicine.

But even though buyer and seller now use other professionals to assist in the transaction, none can set for certain the "true value" of the busi-

Continued on page 530

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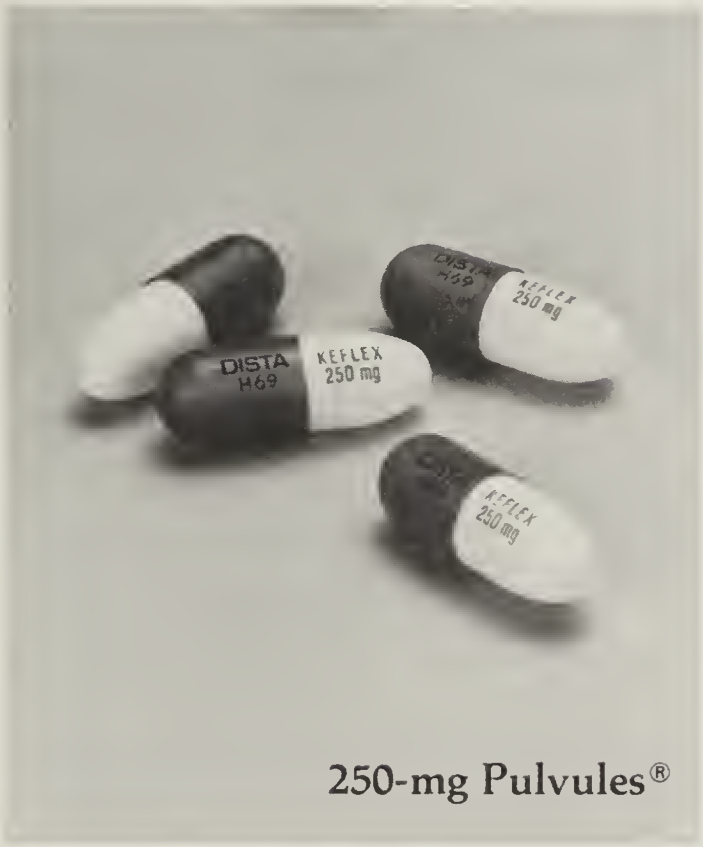

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ness. Searching for certainty in arriving at the "true value" of a practice leads to disappointment because there is no universally accepted method or formula which will unfailingly lead to that magic number.

Not setting a purchase price at the outset of a sale thus may be the wisest course to follow.

A medical practice often derives more value from its ability to generate income for its owner than from tangible assets like fixtures and equipment. Whether it is labeled as good will or allocated to items like covenants not to compete or to consulting agreements, the value is just a recognition of the business's income-producing ability. Thus, a more accurate picture of a practice's value evolves only after the purchaser begins to operate the business.

Setting a firm price for the intangible portion of the practice at the front end of a sale is perhaps the least fair method since no one can accurately foresee the impact of declining economic conditions, the increasing supply of medical services, restrictive insurance regulations, and most importantly, the effect of losing the key person in the business.

Conversely, if the practice prospers, there is no reason why the seller should not share in the good fortune, as it was the seller who built the base from which the purchaser reaps benefits.

Future performance

So how do you agree upon a fair price without setting a price? The answer is to let the future performance of the business and its buyer determine the ultimate compensation paid. Of course, the agreement of sale must set the parameters of the transaction, including a guaranteed minimum price. It should fix the price of the hard assets, and set the formula to be used for the intangibles. But at the outset, it should not fix the actual total.

In determining a formula for valuing the intangibles, some function or multiple of gross revenues or of total compensation is an important factor. One year's total compensation, or a percentage of annual gross revenues, is often a starting point for valuing intangibles. Before fixing a formula, factors such as an upward or downward trend in business expenses, revenues and profits should be considered. Whether patients are referred by other doctors or other patients would affect the value to a new physician. Value may be affected by the percentage of patients without insurance or with high deductibles or co-pay. Also, some attrition rate must be factored in, as it is unrealistic to expect all patients to continue with the new doctor. Finally, such factors as the state of the local economy and patients' incomes and employment status are also considerations.

Here is a simplification of how such a transaction could be structured: Assume there are no disputes between buyer and seller as to the price of the fixtures, equipment and supplies, and that seller will allow buyer five years to pay. The sole disagreement is the value of the intangi-

Continued on page 532

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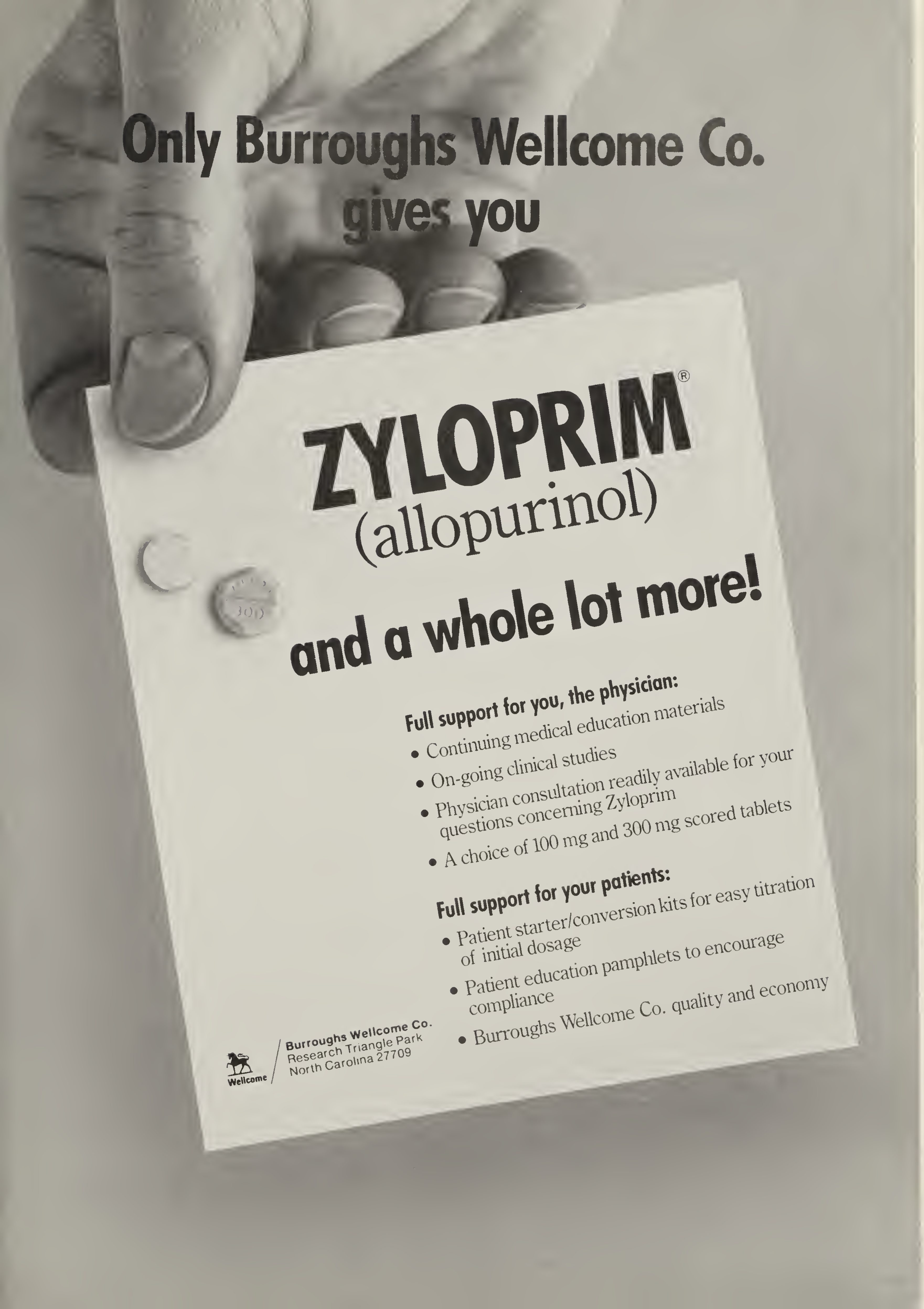

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Your retirement plan: leasing employees

By Dale E. Lamps
Grand Rapids

Mr. Lamps

An important goal of your retirement plan is to provide the owners of the corporation with tax-deferred accumulation of assets. Internal Revenue Service rules require that you also provide your employees with reasonable benefits.

But how can you control the cost of providing the required benefits to your employees?

In the past, one answer to this question has been to lease your workers from an independent firm. Since they were not your employees, you were not responsible for their retirement benefits. They were entirely excluded from the IRS rules on retirement benefits.

TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982) has now arrived on the scene, and closed this "loophole." But at the same time TEFRA opened another, smaller "loophole." Here is the situation:

TEFRA added subsection (n) to Internal Revenue Code Section 414, which states that "the leased employee shall be treated as an employee of the recipient." This means that, for taxable years beginning after December 31, 1983, *leased employees can no longer be excluded from the IRS rules on retirement benefits.* Leased employees must be provided benefits comparable to your normal employees. The loophole has closed.

That's the bad news. The good news is that TEFRA provides you with a new — but less desirable — loophole. TEFRA allows a safe harbor exception on leased employees if certain requirements are met. Here are the requirements:

1. The leasing organization covers the leased employee with a money purchase pension plan.
2. The contribution rate is at least seven and one-half percent.
3. Participation is immediate.
4. Vesting is full and immediate.

Is this seven and one-half percent approach with leased employees the right approach for you? Your first step in finding out is to answer these questions:

1. Do you have access to an efficient and high quality leasing organization?
2. Does that leasing organization cover employees with a money purchase pension plan meeting the seven and one-half percent rules?
3. Would the cost of covering your employees under your retirement plan be in excess of seven and one-half percent of their compensation?
4. Do you regard leasing of employees as a good method of managing your practice?

If you can answer "yes" to these questions, you should further investigate the idea of leasing employees.

Mr. Lamps is senior vice president with Watkins, Ross, Stanar and Lamps, the employee benefits consulting and actuarial firm headquartered in Grand Rapids. He is a fellow of the Society of Actuaries, a member of the Academy of Actuaries and author of many articles relating to the retirement plan field.

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ble, the practice's ability to generate income. After analyzing the practice, which has gross revenues of $200,000, the buyer offers to pay $50,000 for the hard assets and $50,000 for the intangibles. The purchaser is confident of affording that amount from the earnings of the practice based on the gross and projected expenses. The seller responds that the economy and the gross revenues are solid and growing so that the intangibles are worth $150,000 and the sale price should be $200,000.

Buyer cannot afford to pay that price out of earnings based on $200,000 gross. Therefore, a solid stalemate exists. Neither buyer nor seller wants to compromise at $150,000.

Future earnings

The solution is for buyer to guarantee payment of the original $100,000 purchase offer. In addition, every dollar grossed over $200,000 for the next five years will be split 50-50 with the seller until the latter has received $225,000, more than originally sought. The $25,000 extra is the *quid pro quo* for agreeing to a guaranteed payment of only $100,000.

Thus, if the practice is as valuable as claimed, the seller will be handsomely paid for it. Likewise, the buyer will not mind paying that price since those extra dollars come from the profitable end of the gross revenues. If the practice does not gross more than $200,000, it was not worth as much as the seller thought and the buyer should not have to pay for the seller's miscalculation.

In reality, the percentages and the formula would be more finely tuned. The base, over which the seller receives 50 percent, could be increased each year to account for inflation or other increased expenses. The percentage paid to the seller is, of course, negotiable and adjustable. Good sense dictates that the buyer be left with a substantial incentive to strive for good revenues and make the practice grow.

In vitro studies demonstrate

Bactericidal activity

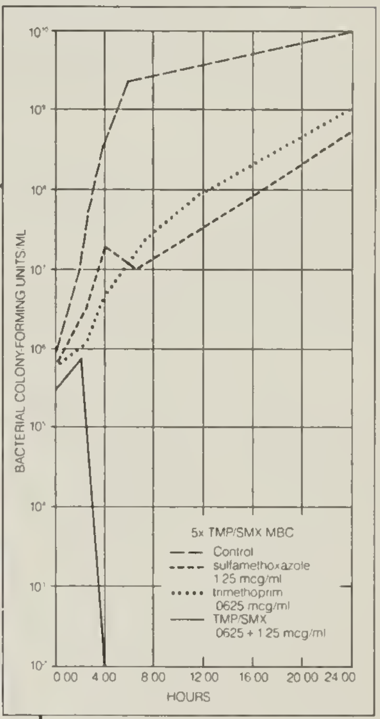
with minimal resistance

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

	Escherichia coli	*Klebsiella pneumoniae*	*Proteus mirabilis*	*Proteus vulgaris*	*Proteus sp.*	*Enterobacter sp.*	*Enterobacter aerogenes*	*Enterobacter cloacae*
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofurantoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI* *



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro.*[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.* Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli.* Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. **3.** Spicehandler J *et al: Rev Infect Dis* 4:562-565, Mar-Apr 1982. **4.** Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections.* Baltimore, Williams & Wilkins, 1980, p. 13. **5.** Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. **7.** Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. **8.** Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. **9.** Iravani A *et al: Antimicrob Agents Chemother* 19:598-604, Apr 1981. **10.** Schaeffer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. **11.** Rous SN: *J Urol* 125:228-229, Feb 1981. **12.** BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS
(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: *Not recommended for infants less than two months of age.*
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Nutley, New Jersey 07110

References:
1. Stone PH, Turi ZG, Muller JE Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of fertility When given to rats prior to mating nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally the following have been reported muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72) and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77° F (15° to 25°C) in the manufacturer's original container

More detailed professional information available on request © 1982, Pfizer Inc

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

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J-9043-4 July 1981

the IMPACT of government & economics on medical practice

MSMS Public Affairs/ Leadership Conference to feature economic, governmental leaders

The heads of the major factions shaping the practice of medicine in Michigan today will speak at the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's Convention Center, Lansing.

Leaders of the AMA, the Michigan Department of Social Services, the legislature, Blue Cross Blue Shield of Michigan, the labor unions, major auto companies and MSMS itself will share their insights with the MSMS members who attend the conference.

Chairman of this year's conference is Fred E. Patterson, MD, Ann Arbor radiologist. Doctor Patterson has planned sessions on marketing; legislative health care cost containment priorities; MSMS initiatives in PPOs, peer review, professional liability, joint venturing and contractual relationships; Chrysler's, labor unions' and BCBSM's perspectives in health care delivery.

Following are biographical sketches of the conference speakers:

Lonnie R. Bristow, MD, FACP, is an internist from San Pablo, CA, who serves as chairman of the AMA Council on Medical Service. He also serves on the new Physician Discussion Group on Physician Reimbursement for the director of the federal Health Care Financing Administration and on the National Council on Health Care Technology. He is a member of the Institute of Medicine of the National Academy of Sciences and a past president of the American Society of Internal Medicine. He currently serves on the ASIM board.

Patrick F. Killeen is senior health care consultant, Social Security Department, International Union of Auto Workers. He has major responsibility for development of collectively bargained health care and related benefit plans for UAW workers. Mr. Killeen is a director of the Health Alliance Plan of Michigan and of the Metropolitan Hospitals and Health Centers and is a member of the Michigan Health Care Economics Coalition.

Walter B. Maher is director, employee benefits and health services, Chrysler Corporation. An attorney, he has been with Chrysler since 1963. He also is a member of the BCBSM Board of Directors, the Greater Detroit Area Health Council Board, the Statewide Health Coordinating Council and Michigan Bar Association.

Agnes Mary Mansour, RSM, PhD, is director of the Michigan Department of Social Services. She was president of Mercy College from 1971 until this year, when she was appointed to the state post by Governor Blanchard. She has been honored as an Outstanding Educator of America, as one of the American Men and Women In Science, by Who's Who in the US, and has served on the boards of directors of Michigan Bell Telephone Company, NBD Bancorp, Inc., and the National Bank of Detroit.

John C. McCabe is president of Blue Cross Blue Shield of Michigan. He is chairman of the national Blue Cross and Blue Shield Association and serves on the boards of its hospital and medical insurance affiliates and its insurance holding company. He is a fellow of the American Health Association and a member of the American Public Health Association and of the American Academy of Medical Administrators.

State Rep. Matthew McNeely (D-Detroit) is chairman of the Michigan House of Representatives Committee on Insurance, a position he has held since 1973. He also is speaker pro tempore of the House and serves on the House committees on education, labor, and state affairs, as well as on the Legislative Council. He is a director of the Michigan Partners of the Americas, past president of the National Conference of Insurance Legislators and co-founder and first president of the National Black Caucus of State Legislators.

Jerry C. Rosenberg, MD, PhD, is chief of the Hutzel Hospital, Detroit, surgical unit. He is on the Transplantation Society of Michigan board, is a member of numerous surgical and immunological societies, is on three scientific publications' editorial boards, and is author of many scientific articles and books.

Rosenberg

Bristow

Killeen

Maher

Mansour

McNeely

McCabe

the IMPACT of government & economics on medical practice

Register today!

1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's, Lansing

Berglund, Bristow, Crandall, Killeen, Maher, Mansour, McCabe, McNeely, and Rosenberg — those are the names of the speakers gathered for the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's Convention Center, Lansing.

Each of these outstanding leaders will bring the benefit of their perspective and expertise to help MSMS members better understand the forces shaping medical care delivery today in Michigan.

The emphasis is on the governmental and economic trends forging the medical environment, as perceived by Chairman Fred E. Patterson, MD, and his committee.

Attendees will receive the MSMS book, "Challenge of the 80s: A Guide to Successful Medical Practice."

Make your plans today to attend this excellent briefing on the medical practice world.

PROGRAM

8:30 REGISTRATION

9:00 OPENING REMARKS — Fred E. Patterson, MD, chairman, MSMS Public Affairs Leadership Conference Committee

INTRODUCTIONS — Thomas R. Berglund, MD, chairman, MSMS Board of Directors

9:05 PUBLIC, SOCIAL AND HEALTH CARE PROGRAMS — Agnes M. Mansour, PhD, director, Michigan Department of Social Services

9:40 THE ROLE OF BLUE CROSS BLUE SHIELD IN HEALTH CARE DELIVERY — John C. McCabe, president, Blue Cross Blue Shield of Michigan

10:15 HEALTH CARE ISSUES: LABOR'S PERSPECTIVE — Patrick Killeen, senior health care consultant, United Auto Workers Social Security Department

10:45 PRIVATE SECTOR STRATEGIES IN HEALTH CARE COST CONTAINMENT — Walter B. Maher, director, Employee Benefits and Health Services, Chrysler Corporation

11:15 YOUR "CHALLENGE OF THE 80s" — MARKETING YOUR MEDICAL PRACTICE — Jerry C. Rosenberg, MD, PhD, chief of surgery, Hutzel Hospital

12:15 LUNCHEON

1:15 INTRODUCTIONS — Donald K. Crandall, MD, president, Michigan State Medical Society

1:20 HEALTH CARE COST CONTAINMENT: A LEGISLATIVE PRIORITY — Representative Matthew McNeely, chairman, House Insurance Committee; chairman, House Ad Hoc Committee on Health Care Cost Containment

2:00 MSMS INITIATIVES: Donald K. Crandall, MD, moderator
  Physicians Review Organization of Michigan (PROM)
  Preferred provider organizations (PPOs)
  Professional liability
  Joint venturing and contractual relationships

2:45 A NATIONAL PERSPECTIVE: CRITIQUE OF CHANGING MEDICAL PRACTICE — Lonnie R. Bristow, MD, San Pablo, CA, chairman, AMA Council on Medical Service

3:45 WRAP-UP — Doctor Crandall

On the conference planning committee are Fred E. Patterson, MD, Ann Arbor; Betty Drew, Bloomfield Hills; Peter A. Duhamel, MD, Rochester; Wayne A. Bare, MD, Jackson, and Willard Stawski, MD, Grand Rapids.

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1983 Public Affairs Leadership Conference
Michigan State Medical Society
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Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

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diazepam/Roche

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For a summary of product information, please turn the page. ROCHE®

Valium® (diazepam/Roche) ⒸIV Tablets
Valrelease™ (diazepam/Roche) ⒸIV slow-release Capsules
Injectable Valium® (diazepam/Roche) ⒸIV

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole tberapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol bave been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL. Advise patients against simultaneous ingestion of alcobol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function, avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, cbanges in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation bave been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or cbest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL. *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months)

INJECTABLE. Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred), repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL. Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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Meet Marguerite Shearer, MD, new MSMS board member

By Willah Weddon
Stockbridge

This article is the first in a series planned on woman physicians in Michigan who are assuming leadership positions.

Breaking precedent is nothing new for Marguerite Shearer, MD, the first female to be elected to the MSMS Board of Directors. She has moved into new areas many times, acting with confidence and the strength of her convictions.

Doctor Shearer, a family physician with a large practice in Dexter, deftly balances her role as a professional with her personal life. The latter includes being married to Marshall Shearer, MD, psychiatrist with an office in Ann Arbor, and mothering their three children.

Ms. Weddon is a Lansing-area freelance writer.

Doctor Shearer's day begins at 7 AM when she leaves her gracious, white-columned home a few miles north of Dexter. She drives to St. Joseph Mercy Hospital, Ann Arbor, or to Chelsea's Community Hospital to make rounds. From there she returns to Dexter by 9 AM to see patients in her office.

Working, training

Doctor Shearer, two other physician-partners in their corporation, and a staff of 14 see patients throughout the day. She is involved in the business affairs for the partnership and the building.

"With a little luck, I have a lunch break," Doctor Shearer says. She has office hours until about 6 PM, seeing patients ranging from newborn infants to one who is 105 years of age. She also makes deliveries at St. Joseph Hospital.

Other professional activities include her responsibility as chairman of the Family Practice Department at St. Joseph Mercy Hospital, member of the board of directors of the Michigan Academy of Family Practice, and chairman of the Medical Care Evaluation Committee of the Area VII Professional Standards Review Organization (PSRO).

Born in Detroit, the 51 year-old physician attended high school in Peck, located in Michigan's thumb area. She entered Michigan State University as a pre-veterinarian student but switched to medical technology.

"During my year of hospital training, I realized medical technology wouldn't be sufficiently satisfying to me," she recalls. She attended Wayne State University, the University of Detroit, entered the University of Michigan's Medical School and graduated in 1960.

She met Marshall Shearer, MD, a resident in psychiatry, while she was a senior at the U. of M. She then completed her internship at D.C. General Hospital in Washington, D.C., followed by a year of medicine residency at Wayne County General Hospital and a year of obstetrics and surgery at Hutzel Hospital in Detroit.

Upon her return to Ann Arbor, the couple married and Doctor Shearer began working for the U of M Health Service. It was during this era — the early 1960s — she became intensely interested in sexual counseling for undergraduates.

"I was appalled at the naiveté of college students," she recalls. "Scholastically brilliant girls would come in pregnant and not know how it happened." She decided to do

Continued on page 542

something about the situation and called on her husband to help. They "let the word out" they'd be available for conferences and were quickly booked a year in advance.

The Doctor Shearer's talks became so well attended and so time-consuming they were moved to the Rackham Auditorium for two annual lectures. Meanwhile, Doctor Shearer was the first Health Service physician to prescribe oral contraceptives to coeds.

"They were opening up visiting hours in dormitories, providing coeducational living situations and removing all curfews," she said. "I thought it was incongruous for the Health Service to remain Victorian and not give the women the contraceptive protection they needed."

When the University told her to desist, Doctor Shearer let it be known that when the University "had the courage to put hours back on the kids and stop the 'open-opens' and the visitations, I'd stop perscribing contraceptions." She never heard any more objections.

Some crusading

At that time abortions were illegal and Doctor Shearer saw many distraught coeds. "They went to Detroit's back alleys for abortions," she said, still horrified at some of the experiences related to her when the women returned to her for post-care.

"We're out of that now, but it frankly worries me that we may be heading back that way," she says.

If there is any crusader in her character, it is over this issue. "I feel very strongly about it," she says. "There is a tremendous inconsistency in political reasoning that espouses such deep concern for the fetus' rights, yet will completely supercede a young adult male's wants and rights with military drafts and assignments to combat zones.

After seven years with the Health Service, the five-foot, four-inch, brown haired physician joined the Chelsea Clinic. Soon after this change the Shearers were invited by Doctors Masters and Johnson to St. Louis, Missouri, for a weekend.

"We were skeptical, but we went," Doctor Shearer recalls. "We were very impressed with their work. We accepted their invitation to join their staff and stayed for two years as research and clinical associates."

When they returned, she rejoined the Chelsea Clinic and Doctor Marshall resumed private practice. They did sexual therapy conjointly for several years on a half-time basis.

With three practices, the pace became too difficult. Doctor Shearer left the Chelsea Clinic and, with two other physicians, built the office near Dexter where she's continued a full-time family practice.

About the time they returned from St. Louis, in 1973, the Shearers began doing a column for the *Detroit Free Press*. Today it is syndicated in the Knight-Ridder newspapers and appears in a number of papers across the nation.

Accepting women

Perhaps Doctor Shearer's attitude, simply expecting to be treated as an equal among her male peers, has contributed to her acceptance in their ranks. She was elected to the MSMS House of Delegates in 1979, a post she continues to hold. She also was elected president of Washtenaw County Medical Society in 1980.

> "The rewards and joys in medicine are the same for women as for men."

"I would encourage all women physicians to join MSMS and to be active," she says. "MSMS membership has given me the opportunity to learn about other issues involving the broader aspects of medicine."

She has been active in putting on MSMS-sponsored programs for women physicians during the past three years. "Some women have felt discriminated against and these issues need to be identified, clarified and rectified," she says.

"The rewards and joys in medicine are the same for women as for men," she continues. "It's a privilege and a responsibility when people come to you for their medical care."

There are some unique contributions women can make to medicine, she feels, such as the fact they've often experienced similar conditions as their female patients. "There is credibility in given situations that would be difficult to grant a male."

"Women are freer to be warm in their expressions than most men can be, as they are less likely to be misunderstood," she continues. "And, it is easier for a woman to talk to some women — they'll hear things they just won't hear from a male."

Pitching in

How does one person, male or female, manage to maintain a balance between a professional career, family life and retain a certain individuality?

The Shearer family consists of three children: Mildred, 19, will be a junior at Kalamazoo College this fall. Christine, 17, will be a Dexter High School senior. Thomas, 13, will enter the eighth grade at Dexter Middle School.

When they built their home, the Shearers included an apartment to house a live-in couple to be near the children. "But basically, the kids have done a lot themselves," Doctor Shearer says.

Located on a rising slope along the Huron River, their eight-acre site contains the fundamentals key to raising a family: a barn for horses (at one time they had 13 Arabians, today they have three), the river for canoeing, a garden for tending and an ample lawn for mowing.

Despite the fast and demanding pace of her professional life, Doctor Shearer manages to spend time with the children and this includes seeing they keep the barn clean.

"Sometimes the best supervision is to do some of the pitching yourself," she comments wryly. The Shearers have been active in school affairs, too, serving on a successful sex education committee for the district.

There are also her own interests to pursue. She likes classical music, enjoys playing the organ, gardening, riding horseback and playing bridge.

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Judicial Commission advises on misconduct, impairment

By Kirk McMurray
East Lansing

Joseph L. Ponka, MD, Detroit, is chairman of the MSMS Judicial Commission.

Commission members are N. Warn Courtney, MD, Kalamazoo; Edwin R. Guise, MD, Detroit; Raymond C. Husband, MD, Detroit; Charles N. Inniss, MD, Detroit; Adam C. McClay, MD, Traverse City; John H. McLaughlin, MD, Birmingham; Richard J. McMurray, MD, Flint; John C. Reinstra, MD, Grand Rapids; George D. Stilwill, MD, Lansing, and A. Stewart Kerr, consultant, Detroit.

The practice of medicine — the preservation of physical and mental health — demands from physicians a firm commitment to serving others. And as the profession's reputation attests, such service is generally well-rendered. Unfortunately, exceptions do occur. Too often when their own well-being or that of a colleague is threatened, physicians fail to respond with characteristic attention and treatment.

The Michigan State Medical Society recognizes physicians' reluctance to acknowledge the existence of emotional, physical, or behavioral problems in themselves or their colleagues.

But physician impairment and behavior contrary to the commitments of professional medical practice do occur. Failure to confront them is both inappropriate and hazardous.

No action *is* an action, an action threatening the well-being of not only the physician, but also the physician's family, patients, and profession.

MSMS/AMA position

In its *Current Opinions*, the Judicial Council of the AMA asserts:

"A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

"An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws." *(Current Opin-*

Continued on page 546

Mr. McMurray is assistant, MSMS Department of Communications and Public Relations.

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ions of the Judicial Council of the AMA, 1982.)

Behavioral obligations for the responsible physician learning of aberrant or negligent conduct, alcohol or drug abuse, emotional problems, or performance-inhibiting physical disability in another physician are clear. The impairment must be confronted.

MSMS agrees with the AMA position. Physician impairment and misconduct are best dealt with through intra-professional efforts unless satisfactory resolution or legal obligations demand outside agency intervention. The following procedural suggestions and description of the MSMS Judicial Commission's activities should help physicians determine appropriate actions by which to ensure proper care for colleagues in need.

Believing physician disability should be confronted simply and directly, MSMS recommends personal counseling — one physician to another — as the initial intermediary measure in impairment or misconduct cases. Expressed concern and support from a colleague may be the inducement a troubled physician needs to begin drawing upon inner resources for problem resolution or even admitting that outside aid is needed.

The success of personal counseling, of course, is not guaranteed. Nor may it be assumed that counseling alone is always sufficient (or desirable) intervention. Prudent measures at the local level also include reporting the problem to appropriate medical staff committees in the hospital and to mediation, ethics, or executive committees of the county medical society. Each has the responsibility and the authority to thoroughly investigate the matter and, in cases of improper professional behavior, take disciplinary action.

Commission's role

Judgments reached through county medical society hearings may be appealed to the MSMS Judicial Commission. Composed of 10 MSMS members, the Commission has the authority to make determinations (in accordance with AMA standards) regarding professional ethics, mediation, grievances, and discipline for all MSMS members. Following review of an appealed case, the Commission will either uphold the decision, refer the case back to the local committee for reconsideration, or, on rare occasion, overturn the earlier decision.

In addition to reviewing decisions, the Judicial Commission can exercise its power of original jurisdiction. At the request of any component society or MSMS member, it can make ethical judgments and opinion statements without first having a case appealed to it. This authority is generally only used in situations where it is felt the local society did not take satisfactory action, the seriousness of the problem warrants early intervention, or the issue clearly affects the entire MSMS membership.

Continued on page 548

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The MSMS voluntary guidelines for physician advertising (*Michigan Medicine*, November 1982) offer an example of the Commission's power to make ethical determinations. Following Supreme Court and Michigan Attorney General rulings permitting professional advertising, the Commission sought to provide physicians with procedural models to follow. The suggestions, of course, simply provide direction to those who seek it. Compliance is neither enforced nor required.

The Judicial Commission also addresses referrals made by the Board of Medicine and the Attorney General's Office. Usually these requests for MSMS involvement are made because the issue of concern is not covered by existing law. Complaints to the Commission made by members of the general public are commonly forwarded to the county medical society of jurisdiction in the case.

Impaired physicians

To ensure troubled physicians receive appropriate health care, MSMS sponsors an active Program to Assist Impaired Physicians. To prevent these physicians from continuing activities which are potentially hazardous to patients and to themselves as professionals, the steering committee for the program works through component medical societies to provide confidential intervention services. It also promotes recognition and rehabilitation programs through local health and well-being committees.

Intervention activities stem from reports of physician alcohol or substance abuse made by colleagues to the MSMS Impaired Physician Committee. An immediate investigation of the situation is performed to determine if a need for intervention exists. If it is considered necessary, a team of physicians and other professionals (including an expert in the problem area) will be formed to confidentially, without threat or judgment, assist the impaired individual. Gentle pressure, a realistic articulation of the physician's plight, and the aid of family and friends all are techniques used to convince him or her that the available help should be accepted. Of those willing to seek help for their problem, approximately 80 percent successfully overcome the disability.

The continuing formation by component societies of health and well-being committees facilitates early identification and evaluation of physicians thought to be suffering from existing or impending impairment. Specifically, the committees try to promote physical and emotional health as essential to both success and happiness, provide help for colleagues in need, and maintain high levels of concern and support for them as they progress through treatment programs and establish active, healthful lifestyles.

Physicians are intelligent, capable people. But they are not perfect. They are as susceptible to emotional, physical, and behavioral problems as anyone else. And when in need, physicians deserve the attention and concern of their colleagues — responsible professionals committed to serving others.

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Michigan delegation plays major role in AMA stand on JCAH manual

By Richard J. McMurray, MD
Flint

AMA
AMERICAN MEDICAL ASSOCIATION

Michigan physicians Billy Ben Baumann, MD, Pontiac, and Robert W. Black, MD, Detroit, played significant roles in June as the American Medical Association House of Delegates forged principles for revising the Joint Commission on Accreditation of Hospitals' Accreditation Manual for Hospitals.

An issue debated at length and deeply by the MSMS House of Delegates, the matter of revising the manual on accreditation also dominated the agenda at the AMA House. Doctor Baumann, a delegate to the House from Michigan, and Doctor Black, an alternate delegate, testified before the reference committee considering the manual revision, then spoke to the floor of the House.

After commending the AMA Board of Trustees for its responsible consideration of the difficult issues connected with the medical staff section of the manual, the House affirmed the following principles as the basis for any revisions in the manual:

- Continue the use of the term "medical staff" in the title of the chapter and throughout the Manual.
- Delete any specific references to limited licensed practitioners now contained in the medical staff chapter of the 1983 *Accreditation Manual for Hospitals*. This does not preclude such practitioners from having hospital privileges consonant with their training, experience, and current competence if approved by the normal credentialing process.
- Provide consideration of qualified limited licensed practitioners in accordance with state law and when approved by the executive committee of the medical staff and by the governing board and, when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience, and current clinical competence of the practitioners.
- Provide that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the medical staff bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (doctors of medicine or doctors of osteopathy) of the active medical staff in the hospital.
- Assure that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (doctors of medicine or doctors of osteopathy).
- Assure that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

Doctor McMurray is chairman of the Michigan Delegation to the AMA.

These AMA reports available at MSMS

MSMS has copies of the following general-interest reports adopted by the 1983 AMA House of Delegates during their annual meeting June 19-23 in Chicago.

The reports listed here are available by contacting Bruce Ambrose at MSMS headquarters, 120 W. Saginaw St., East Lansing 48823.

Medical issues

Genetic Counseling; Artificial Insemination by Donor; and In Vitro Fertilization
Interprofessional Relations with Nurses
Abuse of the Elderly
Commercialism in the Practice of Medicine
Sports Medicine
Reimbursement for CT Scans and Other Procedures
Consumer Choice Principles
FTC Legislation — Status Report
National Vaccine Injury Compensation Program
Arctic Research
Health Insurance for the Unemployed

Medical education

Financial Assistance for Medical Students
Educational Indebtedness and Physician Career Choice
Anonymity for Resident Inquiries to Residency Review Committees
Availability of First-Year Residency Positions and Opposition to Deficit Enrollment
Revision of "General Requirements for Graduate Medical Education"
Teaching Health Economics
Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors

Public Health

The Diminishing Family and Its Impact on Health
Advertising of Prescription Drugs to the Public
Update on Venereal Disease
Current Issues in Pediatric Immunization
Health Care for the Aging and Aged
Pharmaceutical Dissolution of Gallstones
Methaqualone; Abuse Limits its Usefulness
Effects of Physical Forces on the Reproductive Cycle
Choking: The Heimlich Maneuver (Abdominal Thrust)
Combined Modality Approaches to Cancer Therapy
Effects of Pregnancy on Work Performance

Health care delivery

Freestanding Emergency Medical Care Centers
Payment for Physicians' Services
Discontinuance of Federal Funding for Ambulatory Care Centers
Peer Review Improvement Act of 1982
The Insanity Defense in Criminal Trials and Limitations of Psychiatric Testimony
Women Physicians in Organized Medicine

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9 Washington, DC, National Academy of Sciences, 1980, p. 13.

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals
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Auxiliary focuses on young

By Betty Drew
Bloomfield Hills

In this 1983-84 MSMS Auxiliary year, with its program theme of "A Year for Children," our focus follows that of the AMA Auxiliary on children and youth.

Special emphasis will be placed on child abuse, including the positive approach of parent education, as well as identification and treatment.

Closely allied with this is concern with fetal alcohol syndrome (FAS), the only preventable birth defect. Education of both the teenager and adult woman to avoid this condition are priority items. Our Health Projects Committee will be primarily responsible for disseminating information on pertinent films and literature. Representation on the newly formed MSMS Committee on Child Abuse should prove a definite asset for the MSMS/A Health Projects Chairman.

More members

Increasing membership is the top priority item for 1983-84. Our expanded Resident Physician-Medical Student Spouse Membership Committee, which includes wives of practicing physicians from Genesee, Kalamazoo, Kent, Oakland, Washtenaw and Wayne counties, should provide direct information to and cooperation with students' and resident physicians' spouses in these counties.

We hope to emulate the success MSMS had in this area of membership. Because MSMS/A is organized in just 27 counties, our members-at-large comprise a large potential membership, and we are eagerly seeking their involvement. Of equal importance are those members who have supported us so loyally in the past.

The State Medical Society of Wisconsin Auxiliary has issued us a challenge to compete for membership gains for 1983-84. Specifically, they will attempt to gain a greater percentage of new members who are paying county, state and national dues than we.

If they lose, their prize to us will be Wisconsin cheese and sausage. Although they have asked for the obvious from Michigan — an automobile — we have substituted Vernor's ginger ale and Mackinac Island fudge to award them should they win.

In a spirit of cooperation, Delta County Medical Society Auxiliary will host a combined Upper Peninsula-Northeast Wisconsin Medical Society Auxiliary meeting in Escanaba on November 3, 1983.

MSMS/A is in a period of transition. We are striving to be recognized among physicians' spouses as a public relations staff for Michigan physicians, as a support group, a provider of leadership training and a growing legislative power. Please join us.

Mrs. Drew is president of the MSMS/A.

NEWS

By Sheri W. Greenhoe
East Lansing

Bender

Hunt

Reinhart

Smith

Melvin J. Reinhart, MD, Ann Arbor, has been installed as president of the Michigan Psychiatric Society. New president-elect of MPS is **Melvin Bornstein, MD**, Franklin. . . . Brighton Hospital's medical director, **Russell F. Smith, MD**, was honored for 25 years of outstanding contributions by that hospital's board of trustees. Doctor Smith is nationally known for his work in alcoholism treatment. . . . New vice-president of the American Psychiatric Association is **Elissa P. Benedik, MD**, director of research and training, Center for Forensic Psychiatry, University of Michigan Medical School. . . . The Michigan section of the Philippine Medical Association was featured in the May, 1983 issue of the *Philippine American Medical Bulletin*. The group's recent First Scientific Symposium was the subject of the article. . . . **Leonard F. Bender, MD**, Detroit, was recently re-elected president of the Rehabilitation Institute, and **Duane L. Block, MD**, Bloomfield Hills, was re-elected vice chairperson. . . . **Sheila J. Basilisco, CMA**, Plymouth, is new president of the Michigan State Society of Medical Assistants. . . . **Andrew Hunt, MD**, East Lansing, recently was co-leader of the American Pediatric Society Tour of China. In addition, Doctor Hunt was a member of the consultant team to review the National Endowment for the Humanities Medical Ethics Program at the University of Tennessee, and is immediate past president of the Society of Health and Human Values. . . . **Howard Brody, MD**, East Lansing, recently was named to the editorial board of the new journal, "Bioethics Reporter." . . . **Mrs. Saite Ermite**, Dearborn, is new president of the Wayne County Medical Society Auxiliary. . . . **William J. Watts, MD**, Ann Arbor, was one of five charter American College of Chest Physicians Fellows who received a $15,000 research and training award. . . . **Floyd T. Meachum, DO**, Detroit, is new president of the Wayne County Osteopathic Association, and **Randolphe G. Roulier, DO**, Troy, is new president-elect. The group is the na-

Continued on page 554

Ms. Greenhoe is editorial secretary to *Michigan Medicine*.

How to reduce your accounts receivable without lifting a finger.

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Margolis

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tion's largest county osteopathic professional organization. ... "Why Medicine and Gardening Are Great Bedfellows," is the title of an article by **Richard C. Bates, MD**, Lansing, which appeared in the May 16 issue of *Medical Economics*. . . . **Jack Ryan, MD**, Detroit, was named chairman-elect of the Michigan Hospital Association's Board of Trustees at the MHA's 64th annual meeting on Mackinac Island recently. . . . **Harold Kendrick, MD**, Pontiac, president of the Michigan Chapter of the American Academy of Family Physicians, accepted one of three Public Relations Recognition Awards presented by the Academy this year. "Michigan Family Physician Week" was the award winning PR effort. . . . **Robert Mack, MD**, Detroit, was recently appointed to the Michigan Hospital Association Committee on Teaching Hospitals. . . . Recipient of a $16,000 grant from the Michigan Heart Association is **Myron Mychajlonka, MD**, Dearborn. ... **Philip M. Margolis, MD**, Ann Arbor, received a special recognition award at the recent annual convention of the American Psychiatric Association in New York City. Doctor Margolis has been active on the membership committee for the past six years, serving as committee chairman for the last three. . . . **James W. Albers, MD, PhD**, associate professor at the U-M Medical School, was recently elected to the board of directors of the American Association of Electromyography and Electrodiagnosis. . . . **Edwin P. Peterson, MD**, Ann Arbor, is new president of the 8,000 member American Fertility Society. . . . **Leonard DeLooff, MD**, Cedarville, was honored for 25 years of service to the Les Cheneaux area by its residents recently.

Tommy N. Evans, MD, former director of C.S. Mott Center for Human Growth and Development, Detroit, has relocated in Denver. His new address is: T.N. Evans, MD, professor of obstetrics and gynecology, University of Colorado Health Sciences Center, 4200 E. Ninth Avenue, Box B198, Denver 80262. ... **Piero Foa, MD**, West Bloomfield, professor emeritus, Department of Physiology, and **Bennie Zak, MD**, Southfield, professor of pathology, received Distinguished Service Awards from the Wayne State University School of Medicine during recent graduation ceremonies. . . . Recipient of the WSU School of Medicine's Board of Governors Faculty Recognition Award is **Kenneth V. Honn, MD**, Grosse Pointe Woods. Doctor Honn was recognized for his research on anti-metastatic chemicals. ... **Lee Feldkamp, MD**, Plymouth, recently assumed the presidency of the Rotary Club of Plymouth. He is former president of the Michigan chapter of the AAFP. . . . **Robert E. Medlar, MD**, Jackson surgeon, recently retired after 31 years in the operating room. He was team doctor for the local high school football team for 17 seasons. . . .

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CATEGORY I COURSES

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: September 21, The Primary Physician & Cancer Management. Location: Kalamazoo Center Hilton Inn. **Sponsor:** American Cancer Society, Kalamazoo County Unit. **For:** Primary care physicians. **Cost:** $25. **Contact:** American Cancer Society, Kalamazoo County Unit, 123 E. Kalamazoo Ave., Kalamazoo 49007. **Approved for:** 7 hours of Category I Credit.

September 24, Perspectives on Inflammatory Bowel Disease. Location: Somerset Inn. **Sponsor:** Henry Ford Hospital, Office of CME. **Cost:** $100. **Contact:** Medical Education Office, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3072. **Approved for:** 6 hours of Category I Credit.

Date: Sept. 26-28, Advances in Emergency Care. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **Contact:** Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing, 48823. **Approved for:** 9 hours of Category I Credit.

Date: Sept. 29-Oct. 1, New Perspectives in Cardiac Imaging. Location: Hyatt Regency, Dearborn. **Sponsor:** Professional Education Committee of the Michigan Heart Association, and Council on Clinical Cardiology of the American Heart Association. **Contact:** Eleanor D. Peterson, RN, Program Consultant, Michigan Heart Association, 16310 W. 12 Mile Road, PO Box 160-LV, Lathrup Village 48076, (313) 557-9500. **Approved for:** 17 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 3, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 32 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Newer Intravenous Anesthetic Agents and Medicolegal Update. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** U-M Medical School, Office of CME, Depart. of Postgraduate Medicine and Health Professions Education, The Department of Anesthesiology and The Michigan Society of Anesthesiology. **Cost:** $125. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: October 1-2, Burns Clinic 11th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center, P.C. **Cost:** $120. **Contact:** Philip E. Hill, MD, Chairman, Burns Clinic Medical Center, PC, Petoskey, MI 49770. (616) 348-4500.

Date: Oct. 3-7, Advanced Muscle Energy Tutorial (above diaphragm). Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Oct. 6-7, Use of Electron Microscopy in Tumor Diagnosis. Location: Engineering Society of Detroit. **Sponsor:** Dept. of Pathology — Mich. Cancer Foundation and MSMS. **Contact:** J. Russo, MD, Dept. of Pathology — Michigan Cancer Foundation, 110 E. Warren Ave., Detroit 48201 (313) 833-0710. **Approved for:** 14 hours of Category I credit.

Date: October 7-9, 5th International Congress of Laser Medicine and Surgery. Location: The Westin Hotel, Detroit. **Sponsor:** Sinai Hospital of Detroit and the International Society of Laser Medicine and Surgery. **For:** Cardiovascular, Endoscopy, General Surgery, Gynecology, Instrumentation/Biomedical Research, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic, Otolaryngology, Photo-Biology, Plastic Surgery/Dermatology, Podiatry, Urology. **Cost:** $345 before 8/30, $380 after 9/1, $300 Post Grad Med Resident. **Contact:** Fifth International Congress of Laser Medicine and Surgery, c/o Charles B. Slack, Inc., Registration Supervisor, 6900 Grove Road, Thorofare, NH 08086, (609) 848-1000. **Approved for:** 18 hours of Category I Credit.

Date: October 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand and the International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Bldg., 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 1-3, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109, (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Continued on page 560

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

Sept. 24-25 — AMA Leadership Skills Workshop for Women Physicians, Sheraton-Poste Inn, Cherry Hill, New Jersey, contact: Women in Organized Medicine, 535 N. Dearborn, Chicago 60610 (312) 751-6621.

Oct. 10-14 — National Convention, American Association of Medical Assistants, Inc., New York City, contact: Caroline Rich, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 4-5 — "Fall Festival of Knowledge," Fall Leadership Seminar, American Association of Medical Assistants, Michigan State Society, Sheraton Fashion Square Hotel, Saginaw, contact: Caroline Rich, MSMS headquarters.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Feb. 4-5, 1984 — "Through the Looking Glass," American Association of Medical Assistants, Michigan State Society, Mid-Winter Seminar, Amway Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

March 29, 1984 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

April 26-29, 1984 — Annual State Convention, American Association of Medical Assistants, Inc., Michigan State Society, Lansing Hilton Inn, contact: Caroline Rich, MSMS headquarters.

May 4-6 1984 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact Warren Tryloff, MSMS headquarters.

Other meetings

Sept. 22-23 — Third Annual Conference, Society for Public Health Educators, Great Lakes Chapter, Holiday Inn, Mount Pleasant, contact: Rhonda Rush, Van Buren County Health Dept., P.O. Box 307, Hartford 49057, 616/621-3143.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118, (617) 266-9703.

Oct. 10-13 — 35th Annual Convention and Scientific Assembly, American Academy of Family Physicians, Miami Beach Convention Center, contact: AAFP, 1740 W. 92nd Street, Kansas City, MO 64114 (816) 333-9700.

Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209, (703) 528-6405.

November 9-13 — American Medical Women's Association Annual Meeting, Hyatt Regency, Dearborn, contact: Meeting Coordinator, AMWA National Office, 465 Grand Street, New York, NY 10002.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

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Date: November 4-5, Fifth Annual Critical Care Seminar. Location: St. Mary's Hospital, Saginaw. **Sponsor:** Saginaw Cooperative Hospitals, Inc. **Cost:** $100. **Contact:** Hospital Education, St. Mary's Hospital, Saginaw (517) 776-8400. **Approved for:** 12 hours of Category I Credit.

Date: November 11-12 Thirty-first Annual Symposium on Trauma. Location: Kresge Auditorium, Harper Hospital, 3990 John R, Detroit 48201. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Chapter, American College of Emergency Physicians; Wayne State University Department of Surgery. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 9 hours of Category I Credit.

Date: November 12, Borderline Patients: Psychoanalytic Perspectives. Location: The Michigan Inn, Southfield. **Sponsor:** Michigan Psychoanalytic Society. **Cost:** $60. **Contact:** Michigan Psychoanalytic Society, 16310 W. Twelve Mile Rd., Suite 204, Southfield 48076. **Approved for:** 6 hours of Category I Credit

Date: November 13, Sixth Annual Pediatrics Conference. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, MI 48824, (517) 353-8822. **Approved for:** 6.5 (applied for only) hours of Category I Credit.

Date: November 18-20, Manual Medicine to the Extremities. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents principles of manual medicine with emphasis on diagnosis and manipulative management of extremity problems. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: December 3, Michigan Short Stature Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: December 5-9, Basic Principles of Manual Medicine. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents lectures, demonstrations, and practice sessions on the spine, pelvis, and extremities. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: December 10, December Seminar, Michigan Society of Pathologists. Location: Rackham Auditorium, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: March 17-24, 1984. Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Continental Inn, Aspen, Colorado. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 30 hours of Category I Credit.

Burns Clinic annual meeting Oct. 1-2

The Burns Clinic, Petoskey, plans its 11th annual meeting Oct. 1 and 2 at the clinic. The theme is "Meeting the Therapeutic Challenges of Today and Tomorrow."

Attendants will earn 12 Category I hours from the day and a half program, which presents a series of lectures on Saturday and a choice of workshops on Sunday morning. A full spouses program also is planned by Chairman Philip E. Hill, MD, Petoskey.

Details are available from Martha Lancaster or Kay Kelly, Burns Clinic Medical Center, 560 W. Mitchell, Petoskey, 49770.

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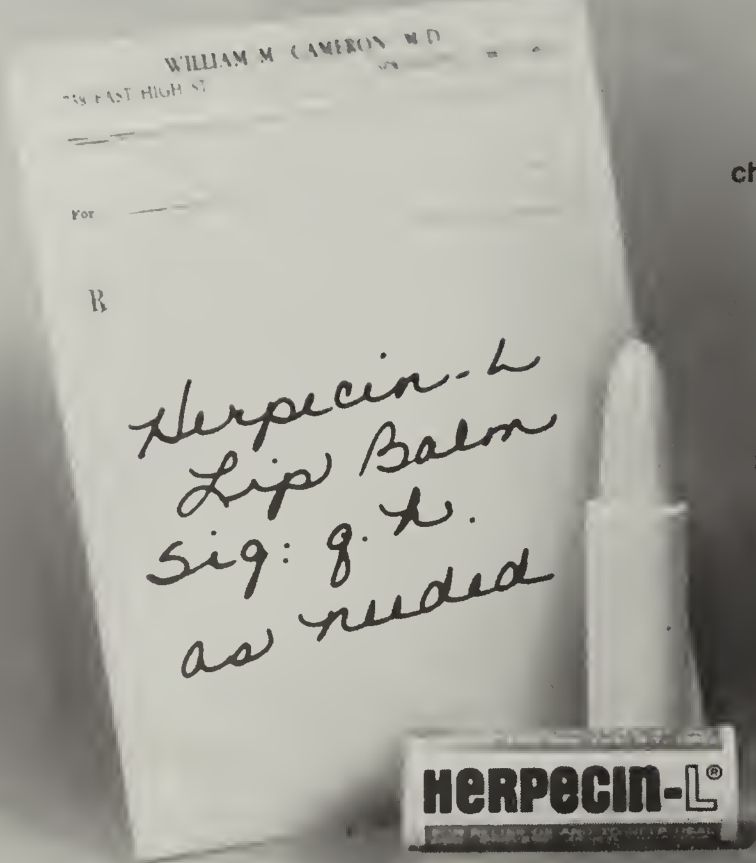

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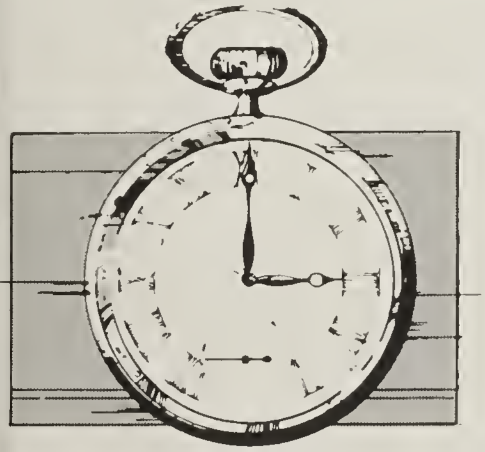

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Positions Open

PEDIATRICIAN WANTED. Temporary, part-time position available immediately. Could lead to a full time, permanent position soon. Detroit-Ann Arbor suburb. Respond with resume to: P.O. Box 2623, Ann Arbor, Michigan 48106 or call: (313) 769-1198 — Sharon.

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POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background for office location in Southfield, Lansing, and Traverse City. An office is planned for Kalamazoo in mid-1983. Other backgrounds in medicine will be considered for the Kalamazoo office. Salary in high 50's with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant (517) 373-7830. In Michigan call toll free 1-800-292-2710.

WANTED — WELL-TRAINED OPHTHALMOLOGIST. Salary first year. Unusual opportunity. Contact: Harry Koenig, MD, PC, 540 E. Division St., Ishpeming, MI 49849

FAMILY PRACTICE PHYSICIAN to join innovative new group practice sponsored by Henry Ford Hospital in Plymouth area, late 1983. Interested persons should send curriculum vitae to Richard Stiphout, MD, Physician in Charge, 19401 Hubbard Drive, Dearborn, MI 48126.

FULL-TIME POSITION AVAILABLE. Emergency Doctors, Inc. is a well-established group of Emergency Physicians in Grand Rapids, Michigan committed to providing competent emergency care to our community. Currently we have a full-time position available. Butterworth Hospital is a busy Grand Rapids teaching hospital with an approved Emergency Medicine Residency Program. Annual patient volume is 35,000 plus. We are seeking a Residency trained or Board Certified Emergency Physician. Estimated base income is $75,000+. Malpractice insurance is fully paid. If you are interested in this position, please contact Amanda K. Stressman, Physician Coordinator at (616) 458-2841 or send your curriculum vitae to Emergency Doctors, Inc., 21 Michigan, NE, Ste. 370, Grand Rapids, Michigan 49503

EMERGENCY PHYSICIANS MEDICAL GROUP in Grand Rapids, Michigan invites resumes from primary care physicians interested in full-time staffing of free-standing urgent care facility. We prefer physicians with a background in family practice or emergency medicine who are interested in assuming roles of leadership in the staffing and operation of the facility. Estimated base income is $75,000 plus. Malpractice insurance is fully paid. Please contact Amanda K. Stressman, Physician Coordinator at (616) 458-2841 or send your resume to Emergency Doctors, Inc. 21 Michigan, NE, Ste. 370, Grand Rapids, Michigan 49503.

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GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimum practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, PO Box 29030, Phoenix, AZ 85038 (602) 954-3506.

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OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full time or part time position. Contact: Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing, MI 48823.

Miscellaneous

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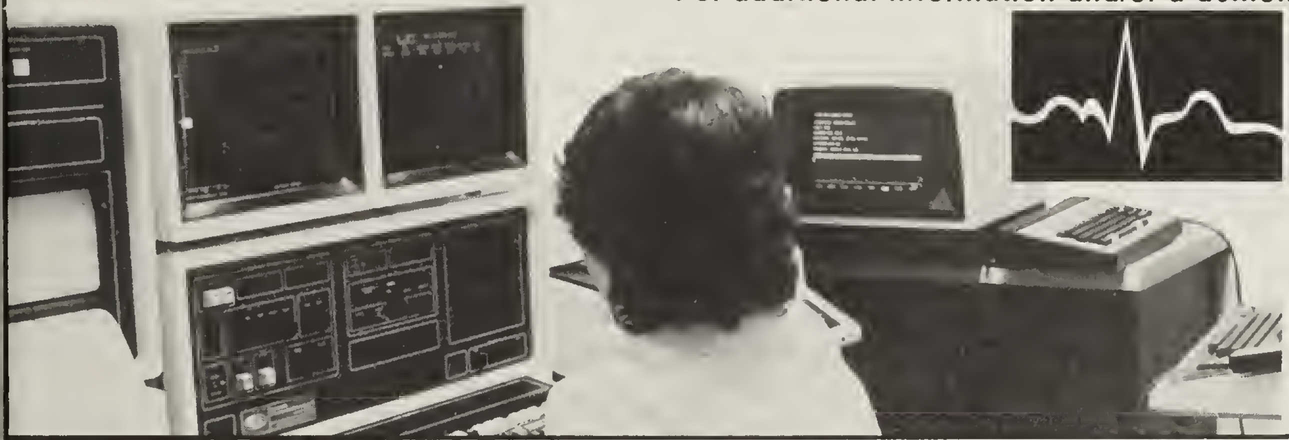

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This month MSMS President Donald K. Crandall, MD, Muskegon, gives his column over to Annual Scientific Meeting Chairman David R. Rovner, MD, for a special message on the meeting.

PRESIDENT'S PAGE

Our Annual Scientific Meeting is best CME value around

David R. Rovner, MD, Chairman
MSMS Annual Scientific Meeting

We MSMS members have one of the best and most economical opportunities around to earn our continuing medical education credits. I mean the 1983 MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn.

You could look a long time before you would find another meeting which focuses more clearly on helping the practicing physician meet the day-to-day needs of caring for patients.

Providing practical, useful information to the working physician is the primary goal of the MSMS Annual Scientific Meeting Planning Committee, which I chair.

A bargain

I'm biased as meeting chairman, of course, but I can assure you that this three-day meeting is a bargain, also. Courses cost just $6 per credit hour for MSMS members. The maximum cost for the three-day conference for a member, therefore, is $108, far below most CME opportunities of equal duration and quality. Other costs are $12 per credit hour for non-members, $5 *per course* for resident physicians and $3 per credit hour for retired MSMS members.

We have tried to provide, within reasonable limits, something for everyone. Thus there is a balance, with a little for everyone and some in-depth probing of particular areas.

Many of this year's courses are designed to help the physician make the best and most economical use of technology in the quest for better patient care. We recognize that it is very easy to overuse high technology. Most of the increase in the cost of health care has been due to the availability of high technology.

Thus, our theme in promotions this year is "MSMS puts you in touch with high tech." This theme also follows the major challenge of MSMS President Donald K. Crandall, MD, Muskegon, who is stressing the need for a "high touch" response to the "high tech" medical era.

Doctor Crandall recognizes, and we are emphasizing, that the physician must develop a compassionate, caring, practical outlook to the use of technology, keeping the patient's needs foremost in mind.

In this magazine are details of topics, directors, and goals of the 55 half-day CME courses being offered during the Annual Scientific Meeting. Also with this issue is a registration form including costs and credit hours to be earned.

Register today

Take the opportunity now to register for this high quality, low cost, practical series of half-day courses. Our excellent faculty members are Michigan and outstate experts who bring you the latest developments and techniques in their fields. Your colleagues who have attended past Annual Scientific Meetings can attest to the exciting learning experience afforded by the lectures and ample discussion time planned.

In addition, the 75-booth exhibit hall provides more learning and hands-on experiences for the attending physician, as well as a place to meet with the day's speakers over coffee or beer.

Before I close, I will list my task force members to express appreciation for their hard work over the past year in selecting courses, ensuring that they meet our standards for improving patient care and in working with course directors to plan the details. A great debt of thanks is owed to Sherry L. Fent, MSMS CME Coordinator and her secretary, Holly Cox.

Committee Members are:
- Frederick W. Bryant, MD, Royal Oak
- Denis F. Cash, MD, Flint
- Edward Cotton, MD, Marcellus
- Dorothy Kahkonen, MD, Detroit
- Kenneth L. Krabbenhoft, MD, Detroit
- Joan C. Stryker, MD, Detroit
- Herbert A. Auer, East Lansing, consultant

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References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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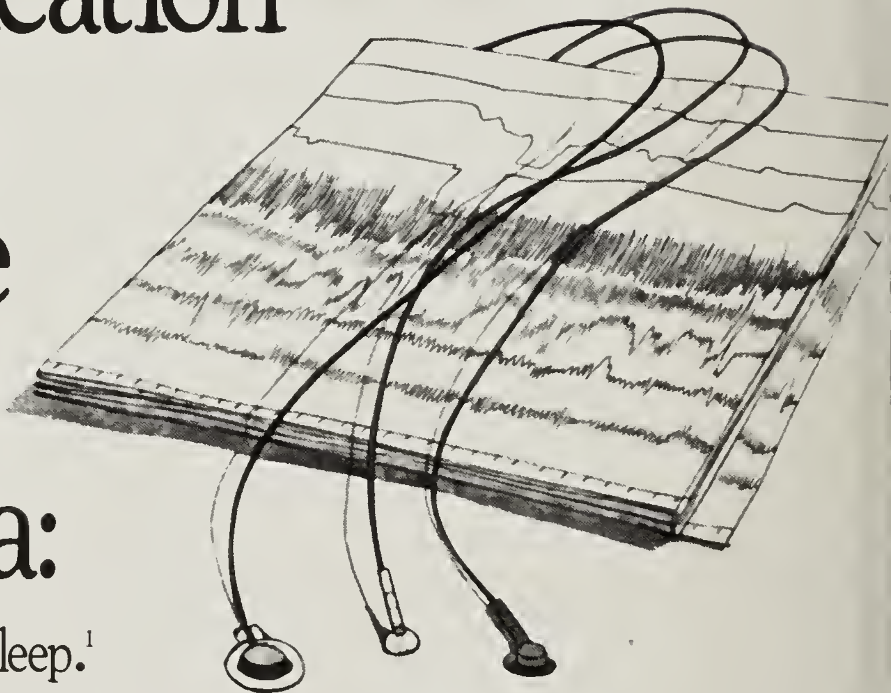

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Vol. 82, No. ~~41~~ 42 September 15, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MSMS MEMBERS CALLED TO SUPPORT SEAT BELT BILL

"Mandatory seat belts will work; this has been demonstrated by the Michigan child seat restraint legislation. Support this life saving issue and let your legislator know you are a supporter of highway safety!" Robert D. Burton, MD, Grand Rapids, MSMS vice speaker and chairman of the Michigan Coalition for Safety Belt Use, is calling on his fellow Michigan physicians to support pending adult seat belt use legislation. Doctor Burton will testify in support of HB 4203 Sept. 28 before the House Insurance Committee. Later that day, General Motors safety personnel will host committee members on test drives to demonstrate how the seat belt helps drivers avoid accidents through better vehicle control. HB 4203 sponsor Rep. David Hollister (D-Lansing) has reintroduced the bill this legislative session (it failed passage 1982-83). Details of the bill, its probable impact, the success of the child seat belt restraint law and Doctor Burton's own seat belt test drive will appear in the October Michigan Medicine. The bill must clear the House Insurance Committee, the full House and then the Senate. Doctor Burton urges every MSMS member to contact local representatives, particularly those who are members of the House Insurance Committee, and urge support of the bill. Physicians may write Chairman Matthew McNeely and committee members at the Michigan House of Representatives, Lansing, 48909. On the committee are Richard Fitzpatrick (D-Battle Creek), Jerry C. Bartnik (D-Temperance), John Bennett (D-Redford), Mary C. Brown (D-Kalamazoo), Dennis M. Dutko (D-Warren), Sal Rocca (D-Sterling Heights), Jelt Sietsema (D-Grand Rapids), Lloyd R. Weeks (D-Warren), John G. Strand (R-Lapeer), Gerald H. Law (R-Plymouth), James Mick Middaugh (R-Paw Paw), Charles L. Mueller (R-Linden), Donald VanSingel (R-Grant) and Paul Wortner (R-Portage).

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LEGISLATURE'S BACK! NEW BILLS UNDER CONSIDERATION

With the Michigan legislature back in fall session as of Sept. 12, the House Public Health Committee will have before it a new bill (HB 4811) aimed at containing health care costs. The bill would prohibit a physician from administering or ordering tests unless he or she obtains the patient's signed consent on a form which clearly describes the test and states its total cost. The bill is sponsored by Rep. Wilbur Brotherton (R-Farmington).

MICHIGAN PHYSICIANS HEAD FOR WASHINGTON

Over 30 Michigan physicians and their spouses will travel to Washington DC Sept. 21-22 for the biannual American Medical Political Action Committee (AMPAC) Political Education Conference. Highlight event will be a national congressional reception. Leading the Michigan group will be Thomas Stone, MD, Muskegon, chairman, Michigan Doctors Political Action Committee; Thomas R. Berglund, MD, Portage, AMPAC secretary, and Donald K. Crandall, MD, Muskegon, MSMS president.

FOOT SURGERY PROGRAM CONTINUES

Chrysler Corporation and the International Union, UAW, have notified Blue Cross Blue Shield of Michigan that they are continuing their Foot Surgery Predetermination Program. The program thus moves out of its pilot phase, which was to have ended Sept. 14, and into more permanent status. The program also applies to General Dynamics Corporation members.

MEDIGRAM, MICHIGAN MEDICINE PROMOTE KEY EVENTS

Recent issues of Medigram and Michigan Medicine have included a number of special features to help Michigan physicians. The August issue published the first of a new series of CME accredited articles and quizzes. The MSMS member who reads the article and successfully completes and returns the quiz can earn category I CME credit for the low fee of $3.

The Sept. 8 Medigram was a special issue, in black and red, on the coming 1983 MSMS Annual Scientific Meeting. MSMS members may plan their attendance through its description of all courses, schedule of special activities, lists of exhibitors and complete registration form.

Other coming MSMS attractions--the Public Affairs/Leadership Conference Oct. 27; practice improvement seminars in four locations during October and November, and the Michigan Conference on Well-Being of Physicians Oct. 14-16 were highlighted in the Sept. 1 Medigram. Registration forms for all three were included in that issue.

CAPSULES

A position statement on preferred provider organizations (PPOs) should be forthcoming from the MSMS Board of Directors, which was to meet Sept. 14 at MSMS headquarters. . . . AMA Board Chairman John J. Coury, MD, Port Huron, is to be the guest on the Sept. 28 "Focus" noon interview program of Detroit radio station WJR. MSMS President Donald K. Crandall, MD, Muskegon, will be interviewed Nov. 9 by "Focus" host J. P. McCarthy. . . . . The MSMS Auxiliary is launching a fund drive at the MSMS Public Affairs/Leadership Conference Oct. 27 and at the MSMS Annual Scientific Meeting Nov. 15-17. Proceeds will go to the Michigan Foundation for Medical and Health Education, to help its support of student loan programs at Michigan's three medical schools. Watch for details!

MEDIGRAM
Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Vol. 82, No. 41 September 15, 1983

Vol. 82, No. 43 September 22, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

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MSMS BOARD ACTIONS

At its regular meeting Sept. 14 at MSMS headquarters, the MSMS Board of Directors:

1) Decided to offer members a multiple employer group life and disability insurance program, and to survey the members on their health insurance needs and willingness to change from Blue Cross Blue Shield of Michigan to a commercial carrier.

2) Authorized the MSMS Physician Service Group, Inc., which now is Michigan distributor of the GTE Telenet Medical Information Network, to subcontract sales and service.

3) Agreed to loan the MSMS Physician Review Organization of Michigan up to $25,000 to prepare a federal PRO bid for Michigan.

4) Approved a five-part position on proferred provider organization (PPO) legislation, which is pending in the legislature. The MSMS position is that PPO legislation should permit flexibility and innovation in PPO systems to encourage new organizations, should include practicing physicians as an integral part of setting standards, should exempt all provider-sponsored PPOs from regulations imposed on third party PPOs, should separate all PPO business done by Blue Cross Blue Shield of Michigan from traditional lines of health insurance, and should require independent outside peer review to assure quality control.

5) Adopted a new Joint Statement on Nurse Midwifery to replace the 1980 MSMS statement.

6) Agreed to develop an MSMS Hospital Medical Staff Section of the MSMS House of Delegates.

7) Endorsed the need for legislation to define and protect the legal status of a child born of a surrogate parent arrangement.

8) Voted to investigate ways to make the resources of the Supplemental Food Program for Women, Infants and Children more available to patients and to educate physicians on use of WIC.

9) Endorsed the AMA Prescription Abuse Data Synthesis (PADS) project and voted to help implement it in Michigan.

INSIDE THIS ISSUE

MSMS members have the chance to register for several important MSMS conferences coming soon. One is the Public Affairs/Leadership Conference Oct. 27 in Lansing; the other is the fall series of seminars on "Improving Your Practice in Today's Competitive Climate," scheduled at four locations around the state. Take a moment today to fill out the conference forms inside.

the
IMPACT
of government
& economics on
medical practice

Register today!

1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's, Lansing

Berglund, Bristow, Crandall, Killeen, Maher, Mansour, McCabe, McNeely, and Rosenberg — those are the names of the speakers gathered for the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's Convention Center, Lansing.

Each of these outstanding leaders will bring the benefit of their perspective and expertise to help MSMS members better understand the forces shaping medical care delivery today in Michigan.

The emphasis is on the governmental and economic trends forging the medical environment, as perceived by Chairman Fred E. Patterson, MD, and his committee.

Attendees will receive the MSMS book, "Challenge of the 80s: A Guide to Successful Medical Practice."

Make your plans today to attend this excellent briefing on the medical practice world.

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2:45	A NATIONAL PERSPECTIVE: CRITIQUE OF CHANGING MEDICAL PRACTICE — Lonnie R. Bristow, MD, San Pablo, CA, chairman, AMA Council on Medical Service
3:45	WRAP-UP — Doctor Crandall

On the conference planning committee are Fred E. Patterson, MD, Ann Arbor; Betty Drew, Bloomfield Hills; Peter A. Duhamel, MD, Rochester; Wayne A. Bare, MD, Jackson, and Willard Stawski, MD, Grand Rapids.

1983 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

Please print or type.

Name ____________________

Address ____________________

____

Name ____________________

Address ____________________

For more information:
Please contact William Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351

Please check one

☐ Physician ☐ Other ________

Registration Fee: $35 for luncheon & "Challenge of the 80s" book
$15 — Students & Residents

Amount enclosed $ ________
Please make check payable to Michigan State Medical Society

PLAN TO ATTEND ONE OF THESE IMPORTANT WORKSHOPS!

"Improving Your Practice in Today's Competitive Climate"

8:15 a.m.	Registration, coffee and rolls
9:00 a.m.	**"Effective, Efficient Practice Management"** Analyzing your practice situation, staffing, collection policies, patient scheduling, etc. John Anthony, Manager, PSG, Inc.
10:40 a.m.	**"Personnel Pointers for Today"** Personnel policies; legal requirements. Vada Davis, MSMS Assistant Administrator
11:35 a.m.	**"So You're Thinking of Buying a Computer?"** Learning to ask the right questions about your computer needs; leasing vs. buying? using a service bureau? John Anthony, Manager, PSG, Inc.
12:30 p.m.	Lunch
1:15 p.m.	**"Communications — The Key to Patient Satisfaction"** Using medical assistants, newsletters, patient information brochures, the telephone and your office to help you communicate more effectively. Mert Scholten, MSMS Chief of Communications
1:45 p.m.	**"Meeting Medicine's Challenges Today"** A hard look into the future as medicine faces problems within and without. Donald K. Crandall, MD, MSMS President
2:05 p.m.	**"Marketing, Maintaining and Building Your Practice"** What marketing is and isn't; developing a marketing plan; adapting to changing markets; marketing tools. Positioning; increasing visibility; attracting and holding new patients; making networking work for you. Gilbert Harrell, PhD, Professor of Marketing, MSU or Jerry Rosenberg, MD, PhD, Chief of Surgery, Hutzel Hospital

- -

Enroll me in the seminar/workshop indicated below. Enclosed is my check for $55 ($95 for non-members) which covers registration, luncheon, breaks, and all course materials.

____ Oakland Co. (10/6)
____ Detroit (WCMS) (10/13)
____ Marquette (10/20)
____ Saginaw (Sheraton) (11/2)

Name ______________________________

Address ______________________________

____

City ____________________ **State** ________ **Zip** ________

Please mail to MSMS, 120 W. Saginaw, East Lansing, MI 48823.
Registrations will be acknowledged with location map, phone number of site.

HHS RELEASES IMPORTANT DOCUMENTS

The MSMS Bureau of Economics alerts MSMS members to the release of two important documents by the Department of Health and Human Services. The documents provide interim prospective payment regulations for Medicare patients under the diagnosis related group payment (DRG) system, and a draft "scope of work" outline for peer review organizations (PROs). Copies of both documents are available from the Bureau.

The "interim, prospective" regulations provide weighting factors for each DRG. Capital related costs and direct medical education costs will be paid on a reasonable costs basis. The regulations sort out reimbursement arrangements for hospitals transferring patients. Physicians will be required to attest, in writing, as to the principal and secondary diagnoses and the procedures performed before a bill is submitted for payment. Reasonable compensation equivalents will not apply to hospital inpatient services paid under the prospective payment system.

According to the draft "scope of work" paper, PROs will be required to review a minimum of five percent of the total admissions, any readmission within seven days of an initial patient visit, admission pattern monitoring, transfers, cutoff points -- both cost and day, DRG validation and procedures such as pacemaker insertion. If an admission is found medically unnecessary, no DRG payment will be made.

SHCC APPOINTMENTS

Gov. Blanchard has appointed the following persons to the Statewide Health Coordinating Council (SHCC): Gloria R. Smith, PhD, director, Michigan Department of Public Health; E. Patrick Babcock, director, Michigan Department of Mental Health; Paul M. Allen, director, Medical Services Administration, Michigan Department of Social Services; Nadyne G. Edison, PhD, deputy director, Michigan Department of Licensing and Regulations, and Dominic A. D'Annunzio, assistant commissioner, Bureau of Insurance. MSMS anticipates physician appointments in two weeks.

REGISTER TODAY FOR 1983 MSMS SCIENTIFIC MEETING

MSMS members are urged to register today for the 1983 MSMS Annual Scientific Meeting, scheduled Nov. 15-17 at the Hyatt Regency Dearborn. Members may use the registration forms in the Sept. 8 Medigram and September Michigan Medicine.

MEDIGRAM

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Vol. 82, No. 43 September 22, 1983

Vol. 82, No. 44 September 29, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

RECALL EFFORTS CAUSE PROBLEMS FOR LEGISLATION

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Legislation affecting medicine in Michigan is joining other bills on the back burner as recall efforts grab legislators' attention. To date, 14 legislators are announced targets of recall petitions. The recall activity, according to Sen. Majority Leader William Faust (D-Westland), will slow the legislative process and will make it difficult for the Senate to get much of anything done this fall. That forecast has a message in it for Michigan physicians seeking passage of the adult safety belt use law and the medical malpractice omnibus bill. In fact, says Rep. David Hollister (D-Lansing), prime supporter of the seat belt bill, the threat of legislative recalls could hurt the chances of HB 4203 from passing. His colleagues "fear another controversy," he says. MSMS will keep members posted.

SCIENTIFIC MEETING SPECIAL EVENTS ON FINANCES, STRESS

By now all MSMS members have the full program and schedule of events for the 1983 MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn. That information appears in the Sept. 8 Medigram and September Michigan Medicine, along with registration forms. Members are urged to register early to ensure their first choices among the 55 half-day Category I CME courses offered.

Meeting Chairman David R. Rovner, MD, East Lansing, directs MSMS members' attention to several evening events planned during the three-day meeting. At 8 p.m. Monday and Tuesday, Nov. 14 and 15, the MSMS Physician Service Group Inc., and the E. F. Hutton Company will present two seminars for physicians and spouses. Subjects, in order, will be investment alternatives and retirement planning. The fee is $10 per physician. At 8 p.m. Tuesday, Nov. 15, the Michigan Health Council will present a "wellness workshop" for physicians and spouses, on reducing and coping with stress. And on the same evening, the Oakland Health Education Program will present a lecture at Meadowbrook Hall, Rochester, for two Category I credit hours. Featured speaker will be a U.S. astronaut, who will discuss the impact of space technology upon the practice of medicine. The fee is $35 and spouses are welcome. Details on each of these special meetings is available from Sherry Fent at MSMS headquarters.

MEDICAID TASK FORCE LOOKING TO NON-MDs FOR COST RELIEF

It is likely that a task force studying ways to reduce costs of the Medicaid program in Michigan may recommend more use of nonphysicians to deliver care to Medicaid recipients. The MSMS Medicaid Liaison Committee reported to the MSMS Board Sept. 14 that the task force, appointed by Department of Social Services Director Agnes Mansour, PhD, seems to have shifted toward expanding Medicaid services and using alternative (i.e., less expensive) providers. This action, the committee observes, seems to be taking the place of reducing program and/or costs. The task force is to complete its work by year's end.

WASHINGTON HOSPITABLE TO MICHIGAN MDs

Over 30 Michigan physicians, guests and staff who traveled to Washington, DC, last week began plans to promote increased physician participation in the 1984 general election. "We don't need to reinvent the political wheel," said Thomas Stone, MD, Muskegon, leader of the Michigan delegation to the biannual American Medical Political Action Committee (AMPAC) Political Education Conference. "What we do need is more physicians taking an active part in local, state and national political campaigns. It is our responsibility." The workshop presented many Washington insiders, including Presidential Advisor Edwin Meese. Meanwhile, individual physicians were busy calling on their congress members and a group spent an hour with Sen. Carl Levin.

'CHALLENGE OF 80s' SEMINAR OCT.6 AT KINGSLEY INN

Physicians in Oakland County may register at the door for the stimulating MSMS "Challenge of the 80s" seminar, "Improving Your Practice in Today's Competitive Climate, scheduled Oct. 6 at the Kingsley Inn. The seminar will feature practice management, personnel management, computer selection, communications and marketing. The $55 registration fee covers lunch and buys the participant the MSMS "Challenge of the 80s" book. For details, contact Mert Scholten at MSMS headquarters, 517/337-1351.

CAPSULES

MSMS members may win a chance at a free Intrav Caribbean Cruise by donating to the MSMS Auxiliary's new fund-raising drive for medical students. The drive, with its theme of "Help Tomorrow's Doctors Today!" will be kicked off at the Oct. 27 MSMS Public Affairs/Leadership Conference in Lansing and at the Nov. 15-17 MSMS Annual Scientific Meeting at the Hyatt Regency Dearborn. Proceeds will go to the Michigan Foundation for Medical and Health Education to support student loan programs at Michigan medical schools. . . . Date to remember--the 1984 MSMS Sports Medicine Conference is scheduled April 12 at Long's Convention Center, Lansing. . . . MSMS and the Michigan Cancer Foundation are cosponsors of a workshop Oct. 6-7 on electron microscopy for tumor diagnosis. The workshop at the Engineering Society of Detroit headquarters will award 14 Category I credits. For details contact Sherry Fent at MSMS headquarters . . . . MSMS testified Sept. 21 before a joint legislative committee on aging. The committee, chaired by Rep. David Hollister (D-Lansing), held a public hearing on health care cost concerns of the elderly.

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Vol. 82, No. 45 October 6, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

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PROM IN BUSINESS

The Physicians Review Organization of Michigan (PROM), founded in 1982 by MSMS, is preparing to begin its review of the appropriateness and quality of medical cases. Monday, PROM received a letter of understanding from Blue Cross Blue Shield of Michigan arranging for PROM review of BCBSM cases, and final language detailing the terms of a contract for review of Michigan Education Special Services Association (MESSA) cases. In the meantime, the PROM board, led by President Frederick VanDuyne, MD, Flint, is analyzing the federal scope of work outline for peer review organizations and is beginning its efforts to win the PRO contract for Michigan. The PROM board meets again on Oct. 12.

PPSP CONSIDERING NEW METHODS TO ENROLL PATIENTS

The Physician Primary Sponsor Plan Steering Committee is considering new methods for enrolling Medicaid patients with Wayne County physicians in the pilot cost containment program. The steering committee met Oct. 3 at MSMS Headquarters to discuss the slow enrollment rate of Medicaid patients in the PPSP. As of Sept. 30, only 23,663 of a potential population of approximately 300,000 had been matched with physician sponsors. The steering committee is considering direct enrollment through the mail or in the physician's office, and enrollment by case workers at redetermination of Medicaid eligibility.

SEAT BELT BILL ON HOUSE FLOOR

The mandatory adult seat belt bill is on the floor of the Michigan House of Representatives after being reported out of the House Insurance Committee Sept. 28. The committee moved the bill to the House floor on a unanimous vote, following its boost by the Automobile Association of Michigan and League General, the credit union insurance company. Both companies announced to the Insurance Committee that immediately on passage of the bill, they would lower personal injury premiums by 20 percent for drivers who pledge to wear seatbelts. That afternoon, legislators were guests of the Michigan Coalition for Safety Belt Use and the Traffic Safety Association of Michigan for demonstrations of seat belt safety in quick stops, evasive maneuvers and skids in highway driving. On hand for the day's events was Robert D. Burton, MD, Grand Rapids, coalition chairman and MSMS vice speaker. Doctor Burton also spent time on the Senate floor with Sen. Paul Henry (R-Grand Rapids).

INSIDE THIS ISSUE

Two of the biggest MSMS meetings are coming soon this fall. And you have an opportunity to register for both with forms inside this Medigram. There is the Public Affairs/Leadership Conference Oct. 27 in Lansing and the Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn. Don't miss them!

the IMPACT of government & economics on medical practice

Register today!

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1983 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

Please print or type.

Name ______________________________

Address ______________________________

____

Name ______________________________

Address ______________________________

For more information:
Please contact William Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351

Please check one

☐ Physician ☐ Other __________

Registration Fee: $35 for luncheon & "Challenge of the 80s" book
$15 — Students & Residents

Amount enclosed $ __________
Please make check payable to Michigan State Medical Society

PLEASE SEND ENTIRE PAGE WITH CHECK

1983 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

***All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.**

TUESDAY MORNING, NOV. 15

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ____ Basic Cardiac Life Support
- ____ Cancer Patient Management in the 1980s: The Role of Radiation Oncology
- ____ Child Abuse: How to Make the System Work for Your Patient
- ____ Diabetes — Current Management and New Developments
- ____ Emergency Psychiatry for the Non-Psychiatrist
- ____ Evaluation and Management of Infertile Couples
- * ____ Flow Cytometry: Clinical Application
- ____ Helping the Troubled Employee: The Role of Physicians and Industry
- ____ Medically-Related Communications Impairments: The Physician's Role
- ____ Traumatic Injuries to the Head, Spine, and Peripheral Nerves

WEDNESDAY MORNING, NOV. 16

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ____ A Comprehensive Review of Anorexia Nervosa
- ____ Arm Pain and Dysfunction: Diagnosis and Management
- ____ Basic Cardiac Life Support
- ____ Esophageal Disorders for the General Physician
- ____ Evaluation and Treatment of the Dizzy Patient
- ____ Identification and Treatment of Chemically Dependent Women
- ____ Marijuana — Its Medical, Legal, and Social Implications
- ____ New Developments and Old Myths About Hyperbaric Oxygen Therapy
- ____ Surgery for the Morbidly Obese

THURSDAY MORNING, NOV. 17

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ____ Basic Cardiac Life Support
- ____ Controversies and Advances in Trauma
- ____ Gastrointestinal Scintigraphy (Imaging)
- ____ Home Health Care Programs: Pediatrics and Adults
- ____ Hypertension — Current Therapeutic Update
- * ____ Medical Use of Lasers
- ____ Recent Advances in Pediatric Hematology
- ____ Scar Control
- ____ Vision

TUESDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ____ Adding Life to Years: Meeting the Needs of the Aged
- * ____ An Overview of the Human Health Effects of Nuclear Weapons
- ____ Chronic Drug Therapy and the Surgical Patient
- ____ Diagnosis and Management of Pelvic Pain
- ____ High Quality Care With DRGs
- ____ Medical Genetics for the Practicing Physician
- ____ Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal
- ____ Pediatric Immunology/Infectious Diseases New Concepts and Treatment Modalities
- ____ Some Burning Issues in Gastroenterology

WEDNESDAY AFTERNOON, NOV. 16

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ____ Allergy Update: Asthma, Foods, and Stinging Insects
- ____ Current Management of Kidney Stone Disease
- ____ Ethical Issues in Ambulatory Care
- ____ Neurological Emergencies — An Approach
- ____ Pediatric Orthopaedics for Family Practitioners
- ____ Pediatric Otolaryngology
- ____ Recent Advances in Neurology
- ____ The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression and Drug Abuse
- * ____ What's New in the Management of Cutaneous Tumors

THURSDAY AFTERNOON, NOV. 17

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ____ Common Gastrointestinal Problems in Children: Diagnosis and Management
- ____ Conservative Treatment of Low Back Pain
- ____ Diagnostic and Therapeutic Interventional Radiology
- * ____ Ophthalmic Outpatient Procedures
- ____ Selected Topics in Pediatric Ambulatory Medicine
- ____ Treatment of Arthritis
- * ____ Unique Techniques in Plastic Surgery
- ____ Update on Common Anorectal Problems
- ____ What's New in Dermatology

The half-day courses will provide three hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/24/83 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, (313) 593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

- -

Name ______________________ ______________________
(please print) (first) (initial) (last)

Street ____

City, State ______________________________ ZIP ____________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ______________ Other ____

Tuition Schedule for Courses:

MSMS members: $6 per credit hour, or $18 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $12 per credit hour, or $36 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch __________ Wednesday lunch __________ Thursday lunch __________
- Indicate total number of half-day courses:

____ x $18 (members) $ ________
____ x $ 9 (retired) $ ________
____ x $36 (non-members) $ ________
____ x $ 5 (residents) $ ________

- Please enroll me in the MSMS/PSG seminars, being held from 8-10 p.m. (Physicians' guests are free.)

Mon. 11/14 "Investment Alternatives for the '80s": ____ ($10 fee) $ ________
Tue. 11/15 "Retirement Plans: Living with TEFRA": ____ ($10 fee) $ ________

TOTAL $ ________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

BRUCE AMBROSE, WILLIAM MADIGAN DEPUTY MSMS DIRECTORS

MSMS Director Warren Tryloff and Board Chairman Thomas R. Berglund, MD, recently announced the promotion of two staff members, Bruce Ambrose and William Madigan, to deputy director positions. Mr. Ambrose is new deputy director and group manager for public affairs and subsidiary operations, while Mr. Madigan serves as deputy director and group manager for communications and internal affairs. Mr. Ambrose has responsibility for legislative affairs, health care policy, state government affairs, medical economics and reimbursement, and the MSMS Physician Service Group, Inc. Mr. Madigan has responsibility for publications, public and media relations, administration, physician education, membership development, meeting planning, finance and building and maintenance operations.

CAPSULES

MSMS takes its "Challenge of the 80's" seminar to the Wayne County Medical Society headquarters building Oct. 13, to provide physicians there with the latest practical advice on "Improving Your Practice in Today's Competitive Climate." Further sessions are planned Oct. 20 in Marquette and Nov. 2 in Saginaw. For details, call Donna Farougi at MSMS headquarters (517/337-1351). . . . The AMA seeks your advice on its proposal to shift to an indemnification form of health care insurance coverage, and to abandon the present UCR system of reimbursement for physicians' services. In the coming October issue, Michigan Medicine presents the AMA's views and provides space for you to reply to the MSMS Bureau of Economics. Please take time to respond on this important issue. . . . The Wayne County Medical Society plans a major conference Oct. 19 on "Ethical Implications of a Changing Medical World." The conference will begin at 1 PM and continue through dinner and early evening. For details, contact Roger Mecum at WCMS headquarters (313/567-1640). . . . The Michigan Chapter, American Medical Women's Association, is host to the annual conference of the national organization Nov. 9-13 in Detroit. Interested physicians may contact AMWA headquarters in New York (212/533-5104).

MEDIGRAM

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Vol. 82, No. 45 October 6, 1983

Vol. 82, No. 46 October 13, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

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MSMS ANNUAL SCIENTIFIC MEETING COURSES FILLING

Registrations are closing already for several category 1 courses planned for the 1983 MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn. These include the Basic Cardiac Life Support Course Wednesday morning, the 16th, which has maximum registrations now. Courses which are filling rapidly include those on diabetes, the dizzy patient, hypertension, allergy, cutaneous tumors and low back pain. ASM Chairman David R. Rovner, MD, East Lansing, and his planning committee urge interested physicians to register now to ensure attending the courses of their choice. A registration form appears on page 3 inside.

MSMS members who wish to stay at the Hyatt during the meeting should reserve rooms today. Rooms set aside for the meeting are being held only until Oct. 21; after that, they will be on an availability basis only. Housing reservation cards are sent by MSMS with every registration confirmation.

Over 350 Michigan physicians have registered for the three-day meeting already. They will attend perennial favorites and new courses such as those on the medical implications of thermonuclear war and on communications impairments. Both of the latter were initiated this year on the mandate of the MSMS House of Delegates. Two interesting courses include one on medical genetics, where the director has reserved half the allotted time for presentation and discussion of participants' cases, and one on esophageal disorders, for which participants are urged to bring their own films for viewbox presentation and discussion.

Register today for this excellent opportunity to earn 18 category 1 credit hours at low cost, to meet with colleagues and to visit booths of 65 commercial and scientific exhibitors.

PROPOSED MEDICARE BUDGET CHANGES AFFECT PHYSICIANS

The U.S. House Ways and Means Health Subcommittee has proposed 25 changes to the Medicare law to meet 1984 budget reduction targets. Three would affect physicians. They call for a six-month freeze at June, 1983 levels on Medicare physician fees for services provided to hospital inpatients; require that MDs accept assignment for all services to hospital patients for six months after HHS secretary reports to Congress on expanding DRGs to reimburse physician services, and establish a national fee schedule for outpatient lab fees under Medicare. The proposals are under consideration by the full Ways and Means Committee; if approved by Congress they are to become effective Jan. 1.

INSIDE THIS ISSUE

You may gear up for retirement with the help of the MSMS Physician Service Group, Inc., and the AMA. The two will present all-day seminars Nov. 30 and Dec. 1 in Lansing and Southfield. The registration form and full details appear inside.

"Gearing Up for Retirement"

A workshop sponsored by the MSMS Physician Service Group, Inc., and the American Medical Association

Wednesday, Nov. 30, 1983
8 a.m. - 5 p.m.
Midway Motor Lodge
7711 W. Saginaw
Lansing, Michigan
517/627-8471

Thursday, Dec. 1, 1983
8 a.m. - 5 p.m.
Michigan Inn
16400 J.L. Hudson Drive
Southfield, Michigan
313/559-6500

Physician Service Group, Inc.

Objective

To answer all your questions on how to painlessly wind down a medical practice and gear up for a successful retirement. This workshop will detail how to close or sell a medical practice. It is strongly recommended that your spouse attend this workshop with you (at no extra charge) because retirement requires planning by both of you.

To Be Discussed

- Physician and spouse role adjustments
- Post-retirement vocational opportunities
- How to close a medical office
- Patient notification, record transfer, and retention
- Valuing a medical practice for sale
- Tax issues of selling a practice
- Post-retirement investments
- Social Security benefits
- Estate planning
- Office and family finances in event of doctor's disability
- Wills and probate, gifts and trusts

For more details,
contact John Anthony or Caroline Rich at MSMS headquarters.

Registration

Registration is limited — REGISTER NOW!
Mail to:
Physician Service Group, Inc., a member service subsidiary of Michigan State Medical Society, Box 950, East Lansing, 48823, 517/337-1351.

( ) Please enroll me in the GEARING UP FOR RETIREMENT WORKSHOP on ______ 1983.

My spouse will ( ) will not ( ) attend . . . (No additional charge for spouse).

( ) I enclose $175. (Fee includes workbook and lunch for yourself and your spouse.)

Name ____________________

Address ____________________

____
City State Zip

Telephone ____________________

PLEASE SEND ENTIRE PAGE WITH CHECK

1983 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

***All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.**

TUESDAY MORNING, NOV. 15

(8:30 to Noon, Including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Cancer Patient Management in the 1980s: The Role of Radiation Oncology
____ Child Abuse: How to Make the System Work for Your Patient
____ Diabetes — Current Management and New Developments
____ Emergency Psychiatry for the Non-Psychiatrist
____ Evaluation and Management of Infertile Couples
* ____ Flow Cytometry: Clinical Application
____ Helping the Troubled Employee: The Role of Physicians and Industry
____ Medically-Related Communications Impairments: The Physician's Role
____ Traumatic Injuries to the Head, Spine, and Peripheral Nerves

TUESDAY AFTERNOON, NOV. 15

(1:30 to 5:00, Including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Adding Life to Years: Meeting the Needs of the Aged
* ____ An Overview of the Human Health Effects of Nuclear Weapons
____ Chronic Drug Therapy and the Surgical Patient
____ Diagnosis and Management of Pelvic Pain
____ High Quality Care With DRGs
____ Medical Genetics for the Practicing Physician
____ Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal
____ Pediatric Immunology/Infectious Diseases New Concepts and Treatment Modalities
____ Some Burning Issues in Gastroenterology

WEDNESDAY MORNING, NOV. 16

(8:30 to Noon, Including break)

(Write 1 in blank for first choice and 2 for second choice)

____ A Comprehensive Review of Anorexia Nervosa
____ Arm Pain and Dysfunction: Diagnosis and Management
____ Basic Cardiac Life Support FULL
____ Esophageal Disorders for the General Physician
____ Evaluation and Treatment of the Dizzy Patient
____ Identification and Treatment of Chemically Dependent Women
____ Marijuana — Its Medical, Legal, and Social Implications
____ New Developments and Old Myths About Hyperbaric Oxygen Therapy
____ Surgery for the Morbidly Obese

WEDNESDAY AFTERNOON, NOV. 16

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Allergy Update: Asthma, Foods, and Stinging Insects
____ Current Management of Kidney Stone Disease
____ Ethical Issues in Ambulatory Care
____ Neurological Emergencies — An Approach
____ Pediatric Orthopaedics for Family Practitioners
____ Pediatric Otolaryngology
____ Recent Advances in Neurology
____ The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression and Drug Abuse
* ____ What's New in the Management of Cutaneous Tumors

THURSDAY MORNING, NOV. 17

(8:30 to Noon, Including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Controversies and Advances in Trauma
____ Gastrointestinal Scintigraphy (Imaging)
____ Home Health Care Programs: Pediatrics and Adults
____ Hypertension — Current Therapeutic Update
* ____ Medical Use of Lasers
____ Recent Advances in Pediatric Hematology
____ Scar Control
____ Vision

THURSDAY AFTERNOON, NOV. 17

(1:30 to 5:00, Including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Common Gastrointestinal Problems in Children: Diagnosis and Management
____ Conservative Treatment of Low Back Pain
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____ Selected Topics in Pediatric Ambulatory Medicine
____ Treatment of Arthritis
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____ Update on Common Anorectal Problems
____ What's New in Dermatology

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Name ____________________
(please print) (first) (initial) (last)

Street ____________________

City, State ____________________ ZIP ________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ____________ Other ____

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Tue. 11/15 "Retirement Plans: Living with TEFRA":	____ ($10 fee)	$ ________

TOTAL $ ________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

EDICAID
OSPICE PROJECT
AS OPENINGS

Medicaid has a project with the Hospice of Southeastern Michigan to demonstrate the cost savings which may be realized with hospice, as opposed to hospital, care of the terminally ill. The project can enroll up to 40 terminally ill Medicaid or Crippled Children recipients by Jan. 15; to date, however, only 12 recipients have been enrolled. Medicaid is anxious that physicians know of this program and make its services available to their patients. Interested physicians should contact the hospice at 22401 Foster Winter Drive, Southfield, 48075 (313/559-9209).

OBBYING ACT
ESS BURDENSOME
FTER COURT MOVE

The Michigan Supreme Court has refused to review Michigan's 1978 lobbyist registration and reporting act. The act, which was challenged by a coalition of interests including MSMS, has been in the court system since enactment, and now is remanded to the lower courts. The challenge succeeded in removing a requirement that membership associations must file their entire membership lists with the secretary of state. The Committee to Protect First Amendment Rights now will turn its attention to compliance seminars to effect the complex legislation.

APSULES

MSMS members may register at the door for the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 at Long's Convention Center, Lansing. The conference will feature speakers such as Agnes Mary Mansour, PhD, director, Michigan Department of Social Services; John C. McCabe, president, Michigan Blue Cross Blue Shield, and Walter Maher, employee benefits director for Chrysler. . . . the MSMS live call-in show, "Housecall," is aired now by Lansing TV station WFSL (Channel 47) at 6:30 PM Sunday evenings. The subject for the physician panel and interested viewers Oct. 30 will be stroke; the topic Nov. 6 will be kidney disease. . . . MSMS is surveying several hundred members to inquire why they have joined local, state and national medical societies. The telephone survey of a selected sample is being conducted by the Kennedy Research firm of Grand Rapids. . . . Watch for a special backgrounder on your options regarding PPOs and joint contracting in the Oct. 20 Medigram. The paper is being prepared by the MSMS Division for Public Affairs and is designed to help the MSMS member act wisely.

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Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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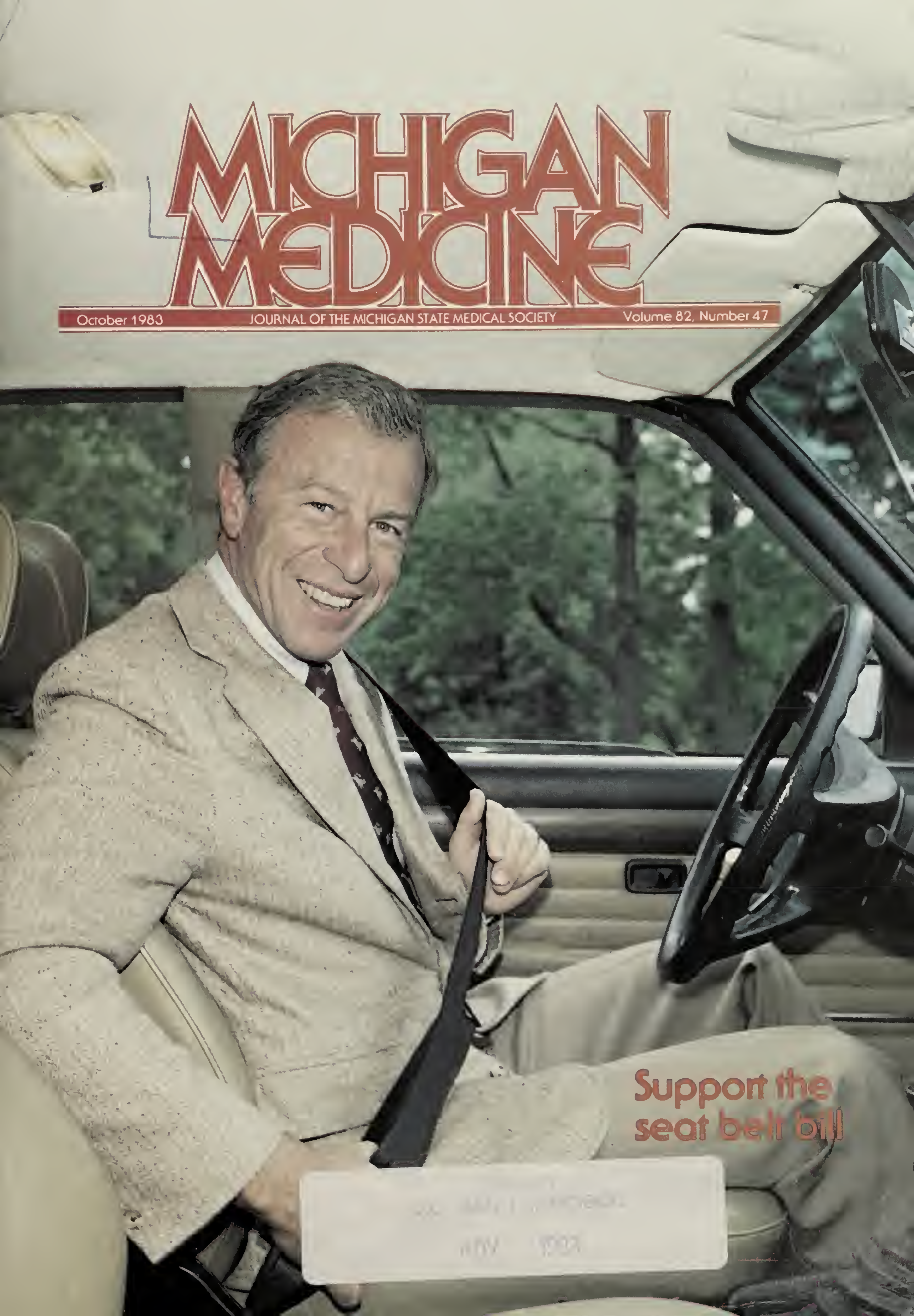
Vol. 82, No. 46 October 13, 1983

MICHIGAN MEDICINE

October 1983 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 82, Number 47



Support the seat belt bill

MSMS puts You in touch with high tech

Advances in technology have changed medical practice and made your touch even more important. The MSMS Annual Scientific Meeting offers 55 CME courses ranging from exploring the physician-patient relationship to an update on laser surgery. Choose now and earn up to 18 hours of Category I Credit. Let MSMS help you "keep in touch."

1983 MSMS ANNUAL SCIENTIFIC MEETING
November 15-16-17, 1983 Hyatt Regency Dearborn

MICHIGAN MEDICINE

Robert D. Burton, MD, Grand Rapids, chairman, Michigan Coalition for Safety Belt Use, buckles up on this month's cover. Doctor Burton, who also is MSMS vice speaker, appears here to emphasize the need for Michigan physicians' support of legislation to make safety belt use mandatory. **(Photo by Roger Hill)**

MICHIGAN MEDICINE
October 1983 Volume 82, Number 47

Special report

569 Michigan physicians' support is very influential to the success of the pending Michigan law on mandatory seat belt use. The legislation is making its way through the legislature as this is written and stands a better chance than it did last year, as the message of saved lives and dollars comes home to our lawmakers. Seatbelts are crucial to maintaining control of a vehicle in many driving situations other than crashes, and that message is brought home in articles in our special report this month. Also included are descriptions of the bill, arguments for and against, estimated savings which would result from mandatory seat belt use and aids to physicians who would like to take up the cause; Robert D. Burton, MD, Judith Marr, Rep. David C. Hollister

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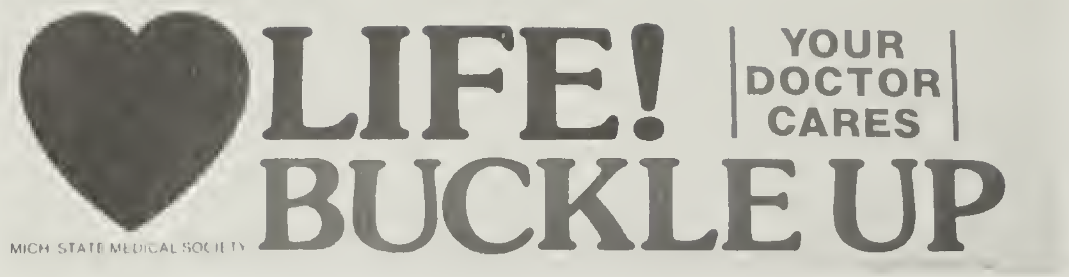

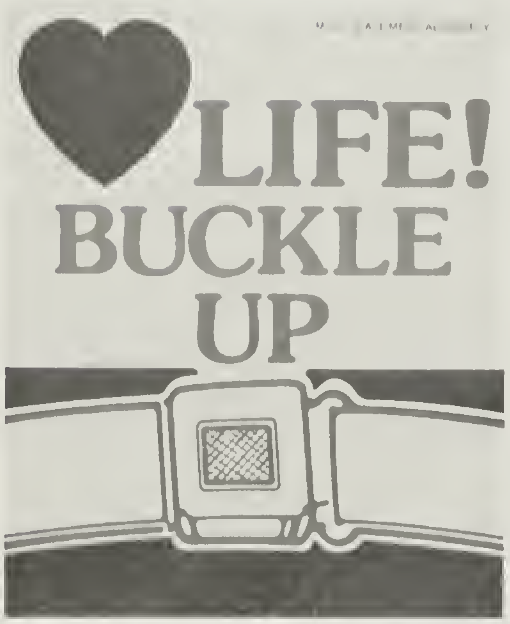

Your Doctor
BUCKLE UP
Cares

MSMS supports legislation to require seat belt use

MSMS can help you promote seat belt use and boost the chances of pending legislation to require that adults wear seat belts. Above are, clockwise from top, bumper stickers, buttons and posters produced this year by MSMS and available at a nominal price for the interested member. Prices of all three appear here, with an order form. Your support of seat belt use will help save lives and prevent injuries.

Please send me: _____ 10 "Buckle Up" bumper stickers Cost: $1.50

_____ "Buckle Up" posters, at no charge

_____ "Buckle Up" buttons. Cost: $27 per 100 lot (available after 11/15/83)

Name ______________________________

Address ______________________________

City ______________________ **Zip Code** __________

(Please send check, payable to MSMS, and order to Ginny Whitman, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.)

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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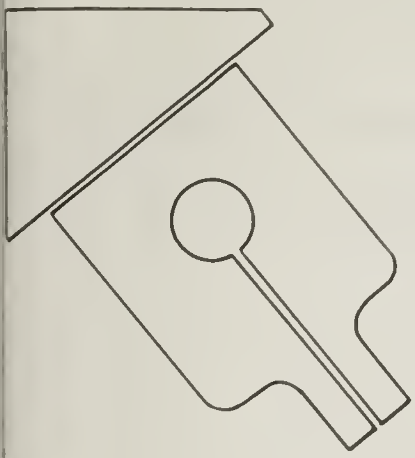
LETTERS



Lapeer County 'new poor'

I would appreciate very much if you could publish an addition to the information I supplied for the article providing the health services for the "new poor" in the June issue of *Michigan Medicine.*

I stated that Lapeer County Medical Society did not have a program of its own and that physicians were helping out on an individual basis.

I failed to mention, however, that the Lapeer Cooperative Health Care Council established the Health Care Network that has been in existence for one year. It consists of doctors, dentists, pharmacists, and other providers who have agreed to supply services to patients who have no health insurance in one of several ways: (1) Extended payment plans; (2) a lesser charge; (3) no charge or payment in kind.

Some of the members of the Lapeer County Medical Society agreed to participate in the program.

Lubomira S. Kocur, MD
President
Lapeer County Medical Society

Dairy Council replies

The May 1983 issue of your publication carried an article by Joseph Arends, MD, "Fifty percent of men, 97 percent of women never physically fit in their lives." While those figures themselves are open to question, the intent of this letter concerns the inaccurate charges that Arends leveled against National Dairy Council. This is the latest in a series of similar unprovoked and unfounded attacks that he has made on the air and in print.

Doctor Arends flatly alleged that NDC "receives approximately three-fourths of its budget from the American Dairy Association as a coerced contribution from farmers from the sale of their milk." This ludicrous claim has no basis in fact.

NDC receives NO money from ADA nor is the support "coerced from farmers." The funds are collected from producers (farmers), processors and equipment/supply manufacturers. The method of payment varies from state to state depending upon local laws and regulations. In every case, however, these people have had a chance to vote for or against participation in NDC programs.

Arends further asserted that "the National Dairy Council preaches the philosophy of a balanced diet, the basic four, or food in moderation. All of these are wrong and deceitful." This claim is nonsensical on its face. It also flies against a teachable, comprehensible food education system developed by the US Department of Agriculture from scientific knowledge.

Arends demanded to know "how could the National Dairy Council, which receives a majority of its budget from the sale of whole milk, possibly talk down the use of butter and cheese? . . . (D)ata accumulated over the past 25 years show quite clearly that our fat intake is excessive and should be reduced."

Had he asked (and he never has), Arends would have learned that NDC, as a nutrition education and research organization, is supported by all segments of the dairy industry. If he had come to us for the truth, he would have further discovered that NDC's position is that there is a dairy food for everyone — specifically including the wide range of low-fat products.

Arends flogs the diet-heart hypothesis while blithely ignoring the many other risk factors of heart disease: heredity, stress, obesity, smoking, hypertension. He also "neglects" to point out that heart surgeon Michael DeBakey, researchers in the Framingham (Mass.) Study (which he sometimes cites) and numerous others have repudiated the concept of imposing therapeutic diets on healthy people.

Michigan Medicine would do its readership a service to insure that its writers substantiate their facts. Arends' allegations against NDC were neither substantiated nor factual.

Dale Kemery
Manager, Nutrition Information
National Dairy Council
Rosemont, IL

World Medical Relief

Amongst your letters in the July issue I noticed the request for medical instruments by World Medical Relief. Please forward to the president of World Medical Relief the following message:

I have available for donation a complete x-ray outfit including mobile x-ray table and 100 KV tube. Would this equipment be of help to your organization? If so, please contact the undersigned immediately.

Klaus Hergt, MD
Cheboygan, MI

Doctor Hergt's donation was passed along to Irene Auberlin, president of World Medical Relief. He is one of many Michigan physicians whose generosity has helped World Medical Relief carry out its mission to help the ill and needy of the world.

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SPECIAL REPORT

Physicians' support crucial to passage of seat belt law

Late in July I spent a day at the General Motors Proving Ground in Milford. With "Doc" R.A. Whitworth at the wheel we went through five simulated auto crash situations as part of their Advanced Driver Education Program. We avoided these five potential accidents without harm through evasive maneuvers and braking made possible only because we were wearing seat belts.

Recently several articles have appeared stating that mandatory seat belts "interfere with personal rights and freedom as a citizen." As responsible drivers all of us desire safety not only in our own automobiles but also the reassurance that the driver in the approaching car can and will control it completely.

If that driver or we are not seatbelted, the necessary emergency control is not possible in many unexpected situations. Mandatory seat belt laws *will work* and have demonstrated this in the Michigan child seat restraint legislation. Support this life saving issue and let your legislator know you are a supporter of highway safety. The life you save may be yours — or mine.

ROBERT D. BURTON, MD
Chairman,
Michigan Coalition for
Safety Belt Use

Please read on in the special report appearing on these pages.

A smiling and confident Robert D. Burton, MD, right, prepares to be guest of R.D. "Doc" Whitworth, left, on a half-hour drive at the General Motors Proving Grounds near Milford. By the end of the drive, which proved without a doubt that seat belts protect passengers and give the driver control of the vehicle, Doctor Burton's grin was as big but his demeanor less poised. For details, continue with the story below.

GM looks to seat belt law to assure public's safety on highways

By Judith Marr, Editor

We were in reverse, accelerating rapidly across the asphalt pad.

Suddenly, our car began to skid, rotating 180 degrees within moments. In the middle of the skid, our driver shifted gears.

We continued our breakneck speed forward. Then the driver made a hard right-hand turn, straightened out for a short distance and threw us into another 180 degree spin. Coming out of that spin, we again were in reverse.

Our tires howled 'no' to every stress, our bodies rocked with the motion.

Perfect control

But because we were wearing seatbelts we emerged without a bump. And that was the point. Not only we were unscathed, but our driver was in perfect control.

He was R.A. "Doc" Whitworth, manager of traffic safety for General Motors Corporation, and it was on "Black Lake," the enormous asphalt surface at the GM Proving Grounds near Milford that he whirled us through his paces.

The purpose of the drive was to demonstrate how seat belts worn properly help a driver maintain control of a vehicle and protect the passengers. This is not just in the event of a crash, Doc emphasized, but in the much more likely event of sudden stops or quick evasions of objects.

The purpose of our visit was to take photographs to promote support of the mandatory adult seat belt bill. With GM's excellent cooperation, we easily accomplished that mission. But we gathered so much valuable information about seat belt use and driver safety in the process that it begged to be shared with MSMS members.

In the front passenger seat was Robert D. Burton, MD, Grand Rapids, vice speaker, MSMS House of Delegates, and chairman, Michigan Safety Belt Usage Coalition. In the back seat with me was Terry D. Horne, senior project engineer, automotive safety engineering, GM Tech Center, Warren.

Before taking the demonstration drive, we had been treated also to a "high G" sled test of a future safety belt system. That test took place in the

Doctor Burton's visit to the proving grounds included a test of a new seat belt mechanism for a future GM model. **Explaining the intricacies of the test in the GM Safety Research and Development Lab was Terry Horne, right.**

large Safety Research and Development Lab at the Proving Grounds.

Our host there, Ronald H. Sutton, general supervisor of the lab, also had arranged for Doctor Burton to view film clips demonstrating the effects upon unbelted test dummies in auto crashes at speeds of 30 mph.

Physicians who have seen similar clips can attest to their effectiveness. It's easy to imagine yourself or loved ones in place of the dummies thrown into windshields and dashboards even at that relatively low speed.

What struck Doctor Burton on viewing the clips this time, however, was the manner in which the unbelted dummies' heads snapped back on initial impact, causing their faces to scrape the shattered windshields. The belted dummies, of course, only rocked forward and back in their seats, suffering relatively mild effects, while the forward portions of the car absorbed the crash.

Belts anchor

"The point of the belt," explained Terry, "is to anchor the person to the car frame, so he rides down the crash as the seat would. The front end of the car crushes in a controlled manner, to take up the impact, so that the person can take advantage of that crush and hold to the frame itself."

Of course, explained Terry, seat belts must be worn properly — low and snug on the hips and across the shoulder — to be effective.

You know how you have doubted that seat belts work at all because if you lean forward suddenly or even jerk the shoulder strap, it gives with you? Terry cleared up that mystery by explaining that the belts work with a pendulum mechanism which only is activated when the car stops suddenly, pitches sideways or otherwise moves violently. The belts are designed to allow freedom of movement in any other cases.

Terry also suggested that those who find the shoulder strap uncomfortably cutting into their necks should move further toward the middle of the car, positioning themselves squarely in the center of their seats, where the belts are designed to work.

Knowing the proper use of seat belts may improve their use, Terry acknowledged. But he expressed GM's reservations that such information will improve the general public's use of belts.

"We think we will not get the mass use across the country unless we get mandatory seat belt laws passed," he said.

The educational materials about seat belt use then will be used to help people feel better about the mandatory aspects of the law, he explained. He pointed out that the US is one of the few major countries without mandatory seatbelt use laws.

And if statistics and filmclips don't do the job, GM could just put the public in Doc Whitworth's hands. He'd convince them.

GM hosted members of the House Insurance Committee recently for some of Doc's seat belt safety demonstration drives. He took additional legislators in groups of three through that nightmarish series of spins, turns

Continued on page 573

Terry Horne introduces Doctor Burton to the highly sophisticated dummies used by GM in its safety research.

Doc Whitworth's tips for safer driving

1. Wear your seat belt in proper position at all times.
2. Sit as far back as possible from the steering wheel, elbows slightly flexed, feet at pedals, with hands on 9 a.m. and 3 p.m. positions.
3. If you are required suddenly to evade an object in your path, ease your foot off the gas and leave the brake alone. Make no more than a 180° turn in the desired direction, then back. At 55 miles per hour, this "evasive maneuver" will take you out of one lane and into the next in 65 feet, while moving you over just one lane.
4. To make a controlled stop, ease off the gas and depress the brake pedal until just before the point of lock. You can stop a car travelling at 55 miles per hour in 110 feet without locking wheels, brakes or losing control. If there is no room for a stop, slam on the brakes, let them lock up and slide.
5. Remember the instruction to always turn in the direction of a skid on ice or snow to pull out of the skid? Forget it! Doc Whitworth's research shows people turn too far in such situations and lose control. Instead, Doc tells students to steer in the direction you want the car to go, with gentle as possible wheel turns. How about front-wheel drive vehicles? Advice is the same!
6. Should your wheels drop off the shoulder of the road, and a quick return to the driving lane be necessary, the driver should ease off gas, avoid the brake, and turn the steering wheel one quarter turn toward the pavement. This causes the tires to assume the proper angle to come back on the pavement. The instant that the driver hears or feels the tires strike the edge of the pavement, he should turn the steering wheel back to the straight-ahead position, bringing the car into the lane of traffic.

Safely belted in, legislators were driven late in September through spins, evasive maneuvers and sudden stops on the MSU driver education instructor training grounds. Automotive test drivers took them through the swerves and jolts to demonstrate how seat belts help drivers maintain control in those highway traffic situations. The goal in the long run was to gain the legislators' support for mandatory seat belt use legislation.

DOC WHITWORTH/*Continued*

and sudden stops at the MSU driver education training course in East Lansing in September. That should assure greater support for the bill.

Central program

Doc is a former race car driver who was technical director of the National Highway Traffic Safety Administration before joining GM in 1969. He researched and designed an advanced driver education program over several years. This program has resulted in the GM Proving Grounds' personnel annual driving safety record of .9 accidents/million miles of driving.

Doc estimates 12,000 persons have been exposed to the program. GM now teaches it to college and university traffic safety centers, who train driver education instructors; to police and fire academy personnel; emergency medical instructors and state school bus driver trainers. These persons in turn share the information with those they train.

Central to the program is seat belt use. As Doc says, "We advocate the use of seat belts because the driver does a better job with the vehicle. The belt keeps you behind the steering wheel."

Never mind that a seat belt could save you from serious injury or even death in an accident, continues Doc. Think of the times you must stop suddenly, swerve to avoid an animal or accidentally drop your tries off the edge of the road. You need a seat belt as much then as in an accident, he points out, to help you maintain control of your car.

Off the road recovery is the leading cause of single vehicle accidents, says Doc.

Doc told Doctor Burton and me that the general public has little idea how much its automobiles can withstand. He lectured that it's extremely difficult to roll a car over, and that tire blowout is so uncommon that his test drivers never even consider it as a factor in their work.

He taught us to maintain control of a car and drive it out of potential catastrophe.

Then he proved it to our satisfaction, running us on and off the shoulder of the Proving Ground's skid pad, driving us head-on into barriers and evading them expertly at the last second, performing skidding j-turns and "laying doughnuts" on the asphalt.

These are the evasive maneuvers and skid control exercises Doc's program teaches, and that he's been putting legislators through. Then he asks them, "How would you like to have done this without your seat belt?"

The secrets to control, and safer driving, he demonstrates, are seatbelt use, leaving the brake alone, easing up on the gas, and steering your way out. The only after-effect of Doctor Burton's and my experience that summer noon at the proving grounds was the smell of hot rubber.

Oh, and there were my queasy stomach and our unsteady legs. Doctor Burton's hair actually was standing on end. "You'll be all right!" Doc boomed heartily after us as we made our way back to more conventional driving.

He was right, as we'd been wearing our seat belts.

Pros and cons of seat belt law and the MSMS position

HB 4203, Michigan's proposed mandatory seat belt legislation, is sponsored by Rep. David Hollister (D-Lansing), and rests in the House Committee on Insurance.

HB 4203 would amend the Michigan vehicle code to require seat belt use by the driver and front seat passengers of an automobile. This legislation is identical to a bill introduced during the last session which died on the house floor.

Key features

Exemptions from seat belt use are granted for:

a. Vehicles manufactured prior to January 1, 1965.

b. Vehicles equipped with air bags.

c. Buses or school buses.

d. Motorcycles, mopeds, vehicles operated by rural mail carriers and vehicles not required to be equipped with safety belts under federal law.

e. Individuals possessing written verification from a physician indicating that the individual is unable to wear a safety belt for physical or medical reasons.

Failure to wear a safety belt will be a civil infraction.

a. No points shall be assessed for a violation.

b. The fine shall not exceed $10.

Failure to wear a safety belt shall not be considered evidence of negligence nor limit the liability of an insurer nor diminish recovery for damages arising out of the ownership, maintenance, or operation of a motor vehicle.

The legislation will automatically sunset in three years.

Arguments for

1. Statistics show that the incidence of serious injury and death are drastically reduced through the use of safety belts.

2. The legislation will not costs any money. Safety belts are already standard equipment in all motor vehicles manufactured since January 1, 1965.

3. Dollars and lives will be saved. A recent University of Michigan study showed that the citizens of Michigan could save about $200 million per year through a reduction in both direct and indirect costs associated with motor vehicle crashes. Total direct costs to the state in 1980 were $21.5 million (including rehabilitation, Crippled Children Fund, Workers Compensation, ADS, welfare, etc.).

Arguments against

1. HB 4203 will be an infringement on individual rights and freedom.

2. A seat belt law will provide law enforcement officers with another tool for harassing individuals.

The MSMS position

The 1982 MSMS House of Delegates passed Resolution 9-82A as follows:

"Whereas, a serious health problem in Michigan is related to injuries sustained in motor vehicle accidents; and

"Whereas, these injuries have a significant impact on the victim and on the remaining segment of society as well; and

"Whereas, it has been established that use of seat belts are beneficial in minimizing the extent of these injuries; therefore be it

"RESOLVED: That MSMS pursue the passage of a mandatory seat belt use law by the Michigan legislature."

The Michigan State Medical Society supports the passage of HB 4203. MSMS Vice Speaker Robert D. Burton, MD, Grand Rapids, chairs the Michigan Coalition for Safety Belt Use.

How seat belts would save us

Here are the savings estimated by the Michigan Coalition for Safety Belt Use if all Michigan citizens were required to wear seat belts.

Some relevant Michigan traffic safety facts (All figures 1981)

Number of highway deaths	1,589
Number of injuries on highways	136,455
Number of serious injuries on highways	19,842
Estimated number of lives lost that could have been saved by full use of safety belts	300
Estimated savings related to decrease in highway deaths by full use of safety belts	$100 million
Estimated number of serious injuries that could have been avoided by full use of front safety belts	8,000-10,000
Estimated savings related to decrease or elimination of serious injuries by full use of front safety belts	$100 million
Total losses incurred by all auto insurance companies in Michigan in 1981	$1.15 billion
Total direct losses to the State of Michigan resulting from auto injuries and deaths in 1980 (includes rehabilitation, welfare, litigation, special education, crippled children's fund, ADC, Medicaid, Workers Compensation)	$21.5 million
Estimated percentage of motorists now wearing safety belts	11%
Percentage of vehicles now equipped with safety belts	99%

Seat belt bill sponsor answers the critics

"I don't want someone to tell me I have to wear a seat belt. I can make that decision for myself. It's none of their business."

That is the most common reaction to the proposed mandatory adult seat belt use law from those who don't support it. And how do supporters reply? Read chief sponsor Rep. David Hollister's remarks below:

I introduced HB 4203 at Secretary of State Austin's request after careful study and research on the issue. I am absolutely convinced that it is the appropriate public policy for Michigan. I think that the evidence is overwhelmingly supportive of legislating its usage, at least for a three year trial period.

By far the greatest concern raised in letters and phone calls is that this legislation would violate a person's constitutional rights and freedoms. This concern outweighs all others four to one.

A privilege

I maintain, however, that driving is not a constitutional right. It is a privilege of citizenship — one that is legitimately regulated by the state. Even now we *require* a driver to take and pass a competency test before a license is given. The license is *required* to be carried at all times. The individual's driving behavior is regulated by speed limits, traffic signs and other limits. These limits are generally aimed at maintaining safety and limiting the risks of driving. If one violates these limits, one is penalized and assessed points. If one continuously violates the limits, one can have the privilege of driving taken away.

Further, people argue they have the right (freedom) to drink, but the state has an interest in telling them that they must limit their drinking when driving. One does not have the absolute "right" to drink and drive.

I parallel the state's interest with that of hunting. Of course, all Americans have the "right" to hunt, however, the state requires:

1. Hunter safety courses
2. Purchase of a license
3. Wearing of the license at all times
4. Adherence to the laws which (a) limit access to lands, (b) establish game limits, (c) make sure that the weapon is appropriate to the game hunted and the area in which hunting takes place, (d) requires all hunters to wear "orange" hunting gear.

These limits on hunting are well established and accepted. They are clearly intended to balance the "right of hunting" and protection of public safety. The seat belt requirements are the same.

Community involved

Driving is not an individual right. When one gets behind the wheel on the public highway, the entire community becomes involved as there are social consequences to the use or non-use of belts.

If an accident occurs, regardless of cause, the driver suddenly is placed at risk. How the driver responds becomes critical to many others.

1. If one is not belted, one can become a missle that can hurt others in the automobile.
2. If one is not belted, one has a significantly higher risk of head injury and unconsciousness.
3. If one is unconscious, one cannot guide the auto after the collision, nor escape from a fire or a submerged auto.
4. If one is unconscious or thrown about, one cannot control the auto and cannot avoid secondary accidents, bystanders, or other objects.

Most of Western Europe, Australia and the Province of Ontario have enacted Mandatory Belt Usage laws. In all cases, deaths, injuries and dollars lost from auto related injuries have gone down.

Help for making seat belt case

Giving a talk to the local Kiwanis Club? Leading an adult discussion group in your church? Thinking of a letter to the editor?

How about making support of the mandatory adult seat belt law in Michigan your topic?

Sponsors of the bill feel Michigan physicians' support is crucial to its passage. That is why MSMS' own vice speaker, Robert D. Burton, MD, Grand Rapids, is chairman of the Michigan Coalition for Safety Belt Use.

Thomas O. Reel, coalition executive secretary, points out that physicians, as educated, caring leaders in their communities, can be a major force in determining public opinion and action.

"Physicians see the results of lack of seat belt use every day in their work," he says. "They have a first-hand knowledge of the suffering, the monetary cost, the tragedy of wasted human abilities which result from injuries and death in automobile accidents.

"Physicians more than anyone can bring home the message of seat belts' value," he says.

Mr. Reel and his staff can put together for the interested physician a very helpful kit on which to base written or spoken pleas for support of the bill. The kit includes a copy of the bill, a message from primary sponsor Rep. David Hollister, statistics on the numbers of lives and injuries seat belts could save, supporting language from Governor Blanchard and numerous Michigan editorial writers. It also includes full discussion of the primary objection that forcing adults to wear seat belts infringes upon their civil rights.

An excellent presentation of the case is provided by the widely-acclaimed slide tape, "The Safety Belt Program," produced by the Michigan State Police. Lasting 16 minutes with sound and color, it very graphically presents the case for seat belt use from the point of view of the police, who also deal daily with automobile crashes and their human toll.

The slide presentation is available at no charge by contacting local state police posts or the Lansing post, Michigan State Police (517/322-1911).

PLEASE SEND ENTIRE PAGE WITH CHECK

1983 MSMS Annual Scientific Meeting, Hyatt Regency Dearbor
Registration form for Category I CME Courses

*All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.

TUESDAY MORNING, NOV. 15
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Cancer Patient Management in the 1980s: The Role of Radiation Oncology
____ Child Abuse: How to Make the System Work for Your Patient
____ Diabetes — Current Management and New Developments
____ Emergency Psychiatry for the Non-Psychiatrist
____ Evaluation and Management of Infertile Couples
* ____ Flow Cytometry: Clinical Application
____ Helping the Troubled Employee: The Role of Physicians and Industry
____ Medically-Related Communications Impairments: The Physician's Role
____ Traumatic Injuries to the Head, Spine, and Peripheral Nerves

TUESDAY AFTERNOON, NOV. 15
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Adding Life to Years: Meeting the Needs of the Aged
* ____ An Overview of the Human Health Effects of Nuclear Weapons
____ Chronic Drug Therapy and the Surgical Patient
____ Diagnosis and Management of Pelvic Pain
____ High Quality Care With DRGs
____ Medical Genetics for the Practicing Physician
____ Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal
____ Pediatric Immunology/Infectious Diseases: New Concepts and Treatment Modalities
____ Some Burning Issues in Gastroenterology

WEDNESDAY MORNING, NOV. 16
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ A Comprehensive Review of Anorexia Nervosa
____ Arm Pain and Dysfunction: Diagnosis and Management
____ Basic Cardiac Life Support
____ Esophageal Disorders for the General Physician
____ Evaluation and Treatment of the Dizzy Patient
____ Identification and Treatment of Chemically Dependent Women
____ Marijuana — Its Medical, Legal, and Social Implications
____ New Developments and Old Myths About Hyperbaric Oxygen Therapy
____ Surgery for the Morbidly Obese

WEDNESDAY AFTERNOON, NOV. 16
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Allergy Update: Asthma, Foods, and Stinging Insects
____ Current Management of Kidney Stone Disease
____ Ethical Issues in Ambulatory Care
____ Neurological Emergencies — An Approach
____ Pediatric Orthopaedics for Family Practitioners
____ Pediatric Otolaryngology
____ Recent Advances in Neurology
____ The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression and Drug Abuse
* ____ What's New in the Management of Cutaneous Tumors

THURSDAY MORNING, NOV. 17
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Controversies and Advances in Trauma
____ Gastrointestinal Scintigraphy (Imaging)
____ Home Health Care Programs: Pediatrics and Adults
____ Hypertension — Current Therapeutic Update
* ____ Medical Use of Lasers
____ Recent Advances in Pediatric Hematology
____ Scar Control
____ Vision

THURSDAY AFTERNOON, NOV. 17
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Common Gastrointestinal Problems in Children: Diagnosis and Management
____ Conservative Treatment of Low Back Pain
____ Diagnostic and Therapeutic Interventional Radiology
* ____ Ophthalmic Outpatient Procedures
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Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/24/83 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, (313) 593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

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- Indicate total number of half-day courses:
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  ____ x $ 9 (retired) $ ________
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  ____ x $ 5 (residents) $ ________
- Please enroll me in the MSMS/PSG seminars, being held from 8-10 p.m. (Physicians' guests are free.)
  Mon. 11/14 "Investment Alternatives for the '80s": ____ ($10 fee) $ ________
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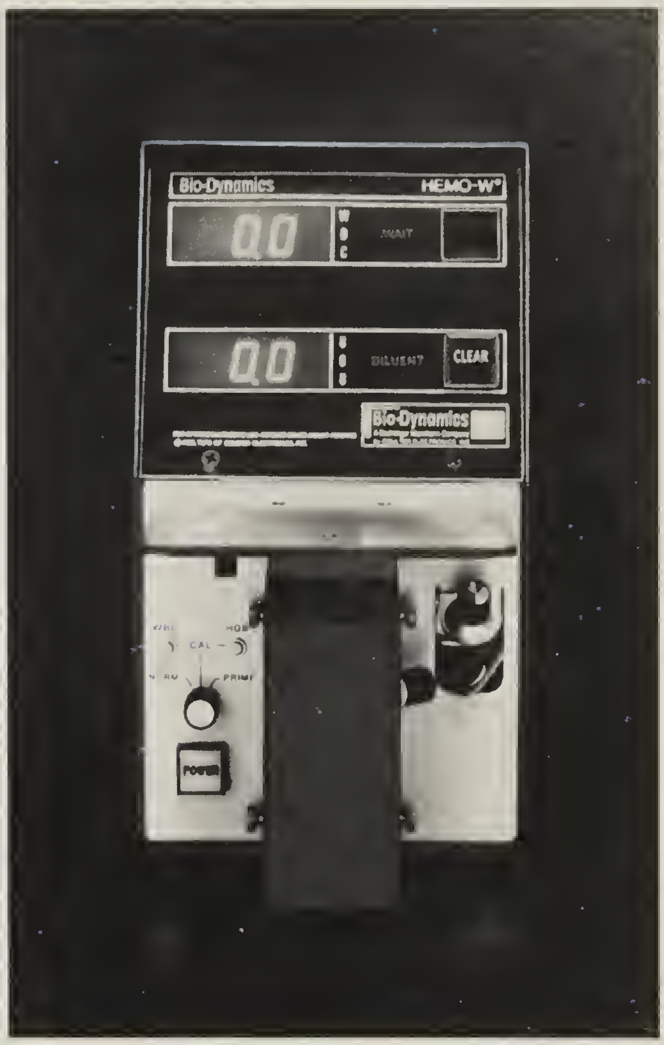

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Continued on page 580

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WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions.* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.
HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.

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Stephanie Mosley, MD
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GTE Telenet Medical Information Network comes to Michigan

By Ellen Vinocur Potash
East Lansing

The MSMS Physician Service Group, Inc., (PSG) a member service subsidiary, announces its new agreement with GTE Telenet Communications Corporation to provide the GTE Medical Information Network (MINET) to Michigan health professionals.

Through the use of a low cost computer terminal or personal computer, Michigan physicians and other health care professionals now can have instant access to the MINET system.

The Medical Information Network is an electronic communication and information system which can be accessed over telephone lines from virtually any computer or terminal equipped with communications capability.

A user dials a local telephone number, plugs into an accoustical coupler (or connects directly via modem), signs onto the system using codes supplied by PSG and the world of electronic communications and information retrieval is entered.

AMA Executive Vice President James H. Sammons, MD, says the AMA/NET programs available for use over the MINET system will become "an increasingly indispensable tool to the physician in the day-to-day practice of medicine. The tremendous growth of new medical knowledge and techniques has sorely tried the ability of physicians to stay up to date. The creation of AMA/NET designed to keep up with today's exponential growth of medical information, was a logical and inevitable step by the AMA."

The data bases

Here is what the GTE/MINET network offers. The system features six AMA/NET data bases that are licensed and maintained by the AMA. These data bases are:

- Drug information
- Disease information
- Socio-economic bibliographic information
- MGH — Category I CME credit offerings of the Massachusetts General Hospital
- EMPIRES — a biomedical bibliographic information base, and
- CPT — medical procedure coding and nomenclature.

In addition, an electronic mail system — MED/MAIL — offers instant transmission of written messages between subscribers.

The drug information data base describes in detail more than 1,200 individual drug preparations marketed under 5,000 trade names in the United States, Canada, and Mexico. The data base offers comprehensive information for each drug by name and identifies drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions. Patient medication instructions (PMI) also are included. One-twelfth of the information base is routinely updated each month; however, critical additions and revisions are made immediately.

The Disease Information base contains current, succinct descriptions of diseases, disorders and conditions. The important diagnostic features of more than 3,500 identifiable

Continued on page 584

Ms. Potash is Project Manager, MSMS/PSG, Inc.

The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative and medical practice information, and soon, abstracts of current clinical literature.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet

Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION PLEASE CONTACT
PHYSICIAN SERVICE GROUP, INC.

A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

ELLEN VINOCUR POTASH
TELEPHONE 517/337-1351

diseases are summarized in a systematic manner, using preferred standard terminology. A signs and symptoms identification tool recently has been added to this data base which is updated twice yearly.

The Socio/Economic Bibliographic Information base serves as a guide for locating current articles on the non-clinical aspects of health care. More than 700 journals are monitored on a continuing basis, making this the most comprehensive bibliographic resource of its kind.

Of particular interest to practicing physicians and other health care professionals are citations to current literature in such areas as cost containment, medical staff relations, insurance reimbursement, legislative initiatives, practice management and the role of the profession in today's society. The data base is updated monthly. An additional feature of this data base is that health professionals may order full text reprints of articles on line from the AMA's Division of Library and Archival Services through MED/MAIL, the electronic mail service of the GTE/MINET.

A new feature of the AMA/NET is called "MGH." MGH is a series of on-line continuing medical education courses most of which offer Category I CME credit. G. Octo Barnett, MD, at the Massachusetts General Hospital supervises development and maintenance of these courses. Doctor Barnett is one of the country's foremost experts in the area of computer medical education.

A participant signing on to the system indicates his/her educational level, clinical experience and specialty and the computer designs an appropriate level case. The cases are interactive in that the user receives basic information, takes a case history, orders appropriate diagnostic tests, establishes a diagnosis and prescribes a course of treatment.

The system provides a summary of the diagnostic information and an evaluation of the diagnosis and prescribed treatment at the conclusion of each case. There also are courses which provide multiple choice answers and an explanation of correct or incorrect choices.

A new and exciting addition to the AMA/NET is EMPIRES, the biomedical bibliographic data base. The acronym EMPIRES stands for Excerpta Medica Physician Information Retrieval and Education Service. The AMA and Excerpta Medica (the Medical Database Publishing Division of Elsvier Science Publishers of Amsterdam, Holland) have selected a set of 310 domestic and international biomedical journals of greatest interest to the American clinician. Excerpta Medica editors select only articles of clinical relevance for incorporation into EMPIRES. Published journal articles are put into electronic form, indexed and cross referenced by medical specialty, transmitted from the Netherlands to Virginia, loaded into MINET, proofed and released into production within 8 to 12 weeks after original publication date. This update cycle will be monthly, moving to biweekly updates later in 1983 and weekly updates in 1984.

EMPIRES is divided into two services. The Current Awareness Service allows users to access current citations and abstracts by AMA specialty and/or subspecialty area. The Service includes articles that have been added to the information base within the last three months, and are less than six months from their date of publication. Users indicate which specialty area interests them, and a list of titles relevant to that area appears on the terminal screen. Titles are listed in order from most current to least current. After the list of titles is displayed, one may select items of interest and indicate whether complete citation or abstract is desired.

The Reference Service contains current and retrospective citations and abstracts of clinical literature. The entire reference base eventually will contain four years' worth of abstracts. Information currently available dates from 1981. Approximately 125,000 abstracts and citations will be available at introduction with about 50,000 abstracts added each year. The user has available information on-line to assist in the accessing of EMPIRES. This includes commands, descriptions, helps, abbreviations and classifications.

The last currently available data base is the Current Procedural Terminology (CPT) Information Base which provides a uniform coding and nomenclature system for reporting medical services and procedures performed by physicians. It contains more than 6,000 descriptions of procedures, with their identifying codes, in the areas of medicine, surgery and diagnostic services. While CPT coding is the most widely used of all systems for reporting and communicating with third party payers, it is not uniformly used in Michigan at this time. However, MSMS anticipates the CPT codes will be accepted as the standard in Michigan in 1984. This information base is updated every four to six months.

MED/MAIL

MED/MAIL is an electronic mail system for subscribers in the medical and health care community. Subscribers can send and receive messages 24 hours a day from any location in the United States. System users could, for example, communicate with colleagues, hospitals, nursing homes, libraries and many other individual and institutional subscribers. Naturally, the value of MED/MAIL grows as the number of system users increases.

There are two features of MED/MAIL other than messaging. The electronic "bulletin boards" contain messages of general interest. MSMS uses its bulletin board to disseminate information of general and particular interest to medical society members who subscribe to the system. A bulletin board is an inexpensive, accurate method of rapidly sharing information with multiple users.

In addition to the general bulletin board feature, the AMA maintains Continuing Medical Education bulletin boards and bulletin boards listing AMA sponsored meetings. The Physician Service Group will assist interested groups in developing other applications for bulletin boards and electronic mail service.

PSG will have a booth at the 1983 MSMS Annual Scientific Meeting and will be demonstrating this exciting new technology. The PSG staff also is available to describe this new service to physicians and other health professionals.

For further information regarding the AMA/NET information services and GTE Telenet Medical Information Network, please contact Ellen Vinocur Potash at (517) 337-1351 or write to PSG, Inc., 1305 Abbott Road, East Lansing, MI 48823.

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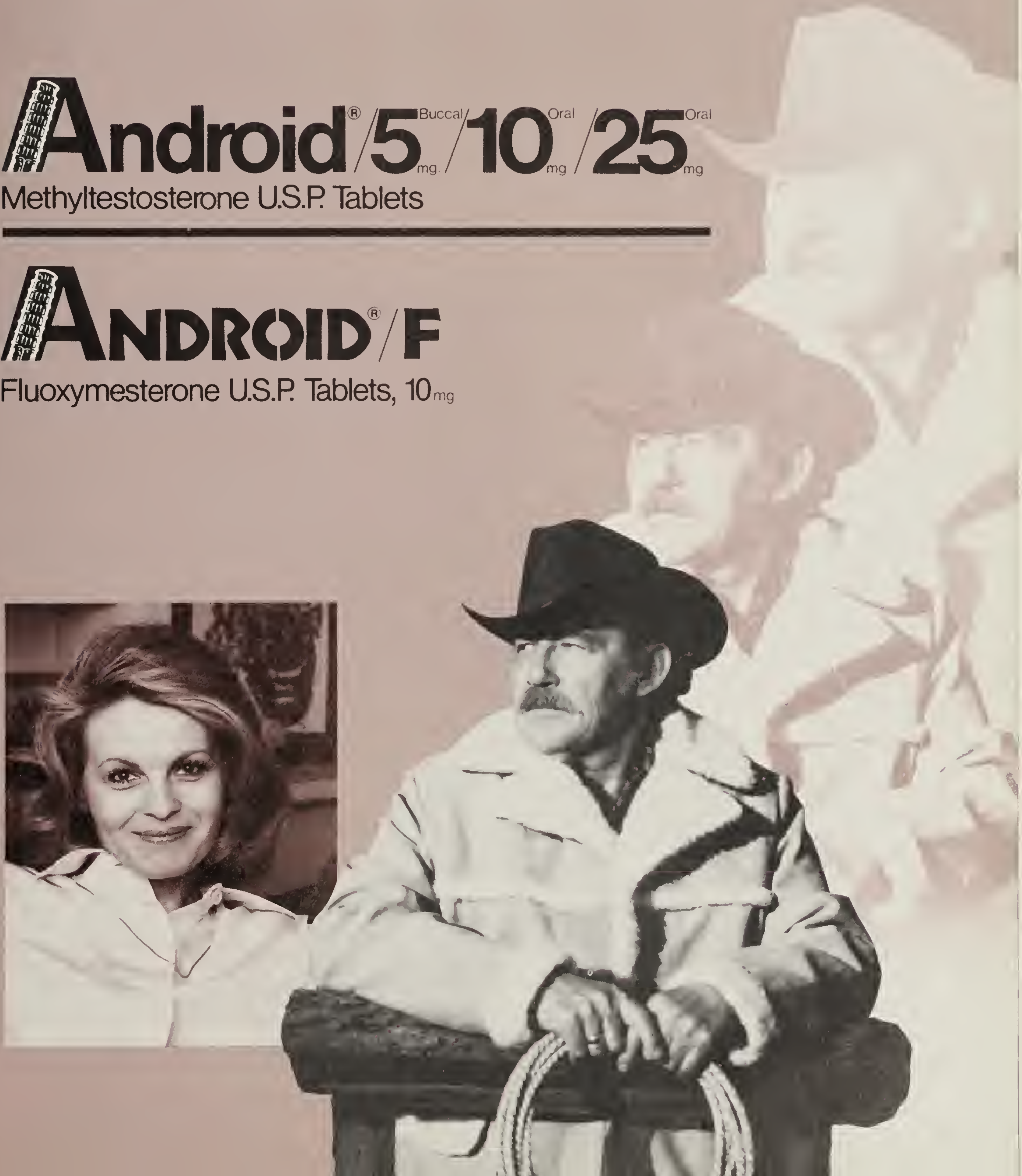

MSMS position on optometry

The following section inadvertently was omitted from the August *Michigan Medicine,* which published an MSMS position statement on alternative health care professionals.

Optometry

Section 333.17401(b) of the Public Health Code defines the practice of optometry as one or more of the following:

"(i) The examination of the human eye to ascertain the presence of defects or abnormal conditions which may be corrected, remedied, or relieved, or the effects of which may be corrected, remedied, or relieved by the use of lenses, prisms, or other mechanical devices.

"(ii) The employment of objective or subjective physical means to determine the accommodative or refractive conditions or the range of powers of vision or muscular equilibrium of the human eye.

"(iii) The adaptation or the adjustment of the lenses or prisms to correct, remedy, or relieve a defect or abnormal condition or to correct, remedy, or relieve the effect of a defect or abnormal condition of the human eye.

"(iv) The examination of the human eye for contact lenses and the fitting or insertion of contact lenses to the eye.

"(v) The employment of objective or subjective means for the examination of the human eye for the purpose of ascertaining a departure from the normal, measuring powers of vision, and adapting lenses for the aid thereof."

MSMS continues its support of this section of the Public Health Code. Any change in this definition of scope of practice would require changes in training and license renewal requirements. If, for instance, authorization to use or dispense drugs were added, thorough knowledge of pharmacology would be necessary. Potential reactions with patients' other medications, contraindications because of systemic disease, and many other factors would have to be considered.

For these and other significant reasons, expansion of this scope of practice is not recommended.

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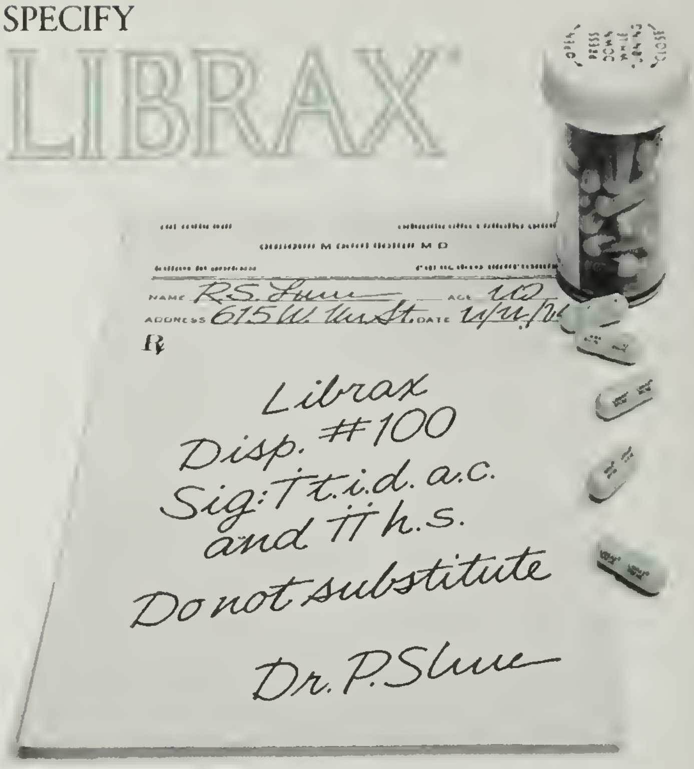

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

* Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.
As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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*Librax has been evaluated as possibly effective adjunctive therapy in the treatment of irritable bowel syndrome and duodenal ulcer. Please see summary of prescribing information on the preceding page.

SPECIFY ADJUNCTIVE
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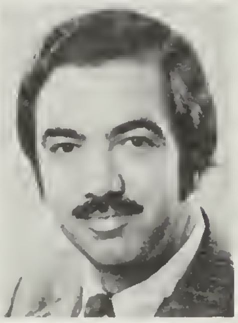
NEWS

By Sheri W. Greenhoe
East Lansing

Blain


Harness

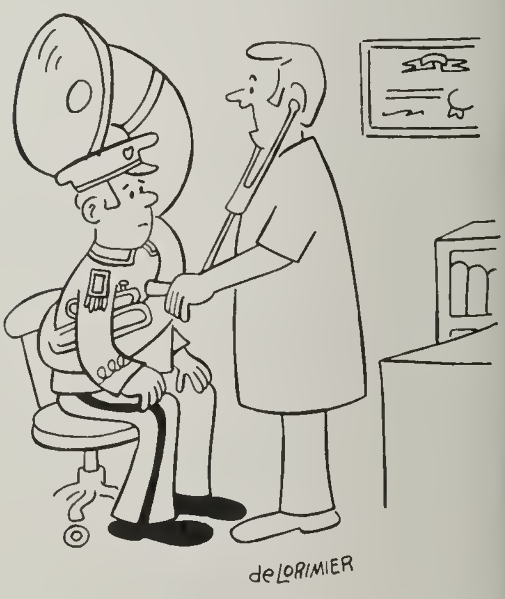
Steinhauer

Szilagyi

Priest

Shaffer

Paul Sobotka, MD, Ann Arbor, is one of six international candidates competing for the Cecile Lehman Mayer Research Award, presented annually by the American College of Chest Physicians. Two $1,000 awards will be given; one for best paper on pulmonary disease, and one on cardiovascular disease. Winners will be announced October 27 at the 49th Annual Scientific Assembly in Chicago. . . . **Jay K. Harness, MD,** Ann Arbor, was named chairman of the board of directors of a newly established National Commission on Correctional Health Care. The commission is made up of representatives from major medical, health, correctional and legal organizations. . . . **Alexander Blain, III, MD,** was honored recently in a ceremony conducted by the Detroit American Indian Health Center, of which he is chief surgeon. He was lauded for distinguished service to the American Indian community. Doctor Blain was featured in the leisure section of the September 7 issue of *Health Care News.* . . . Royal Oak physicians **Seymour Gordon, MD,** and **Bryant Pierce, MD,** were recently elected to leadership positions with the American Heart Association of Michigan. Doctor Gordon was elected association president, and Doctor Pierce was elected to the board of trustees. . . . More than 500 patients gathered recently to honor **Benjamin C. Clyne, MD,** Yale. Doctor Clyne and his late physician father served the medical needs of that community for a combined 100 years. . . . **William P. Gifford, MD,** Battle Creek, is new Calhoun County medical examiner. . . . **Joseph Levy, MD,** Battle Creek, retired from pediatric practice October 1. He is former chief of pediatrics at both Leila and Community hospitals. . . . **Philip Hills, MD,** Petoskey cardiologist, recently returned from a three-week tour of China, where he visited several medical schools and hospitals. Doctor Hill noted that although the country has made great strides in the last 10 years, it is still 40 years behind this nation. . . . **Boy Frame, MD,** Grosse Pointe Park, recently co-chaired the steering committee for the International Bone and Mineral Metabolism Symposium held in Dearborn. Doctor Frame also was elected one of nine regents to the American College of Physicians. . . . The gastroenterology library at Henry Ford Hospital recently was named for **Robert J. Priest, MD,** Detroit. A plaque hangs near the library entrance attesting to Doctor Priest's many contributions to the hospital and the department. . . . New secretary-treasurer of the Michigan Branch of the American Urological Association is **Riad Farah, MD,** Detroit. . . . **D'Anne Kleinsmith, MD,** Detroit, was one of five recipients of WSU's 1983 "Women of Wayne Headliner Awards" which recognize achievements of outstanding alumnae. . . . **Louis Saravolatz, MD,** Detroit, was recently elected to the editorial board of the *American Journal of Infection Control.* . . . **Bruce W. Steinhauer, MD,** Detroit, recently was named a Fellow in the American College of Physician Executives. . . . **E. Emerick Szilagyi, MD,** Detroit, received the National President Award in recognition of his leadership of the Society for Vascular Surgery. He also was named Senior Editor of the new *Journal of Vascular Surgery.* . . . **Lester Weiss, MD,** Detroit, was appointed to the Steering Committee, Division of Services to Crippled Children by the State of Michigan. . . . **C. Paul Hodgkinson, MD,** former chairman of the Henry Ford Hospital department of obstetrics and gynecology, retired recently after 43 years of medical service. . . . **Joseph Shaffer, MD,** senior consultant for the Allergy Division at Henry Ford Hospital retired recently after 52 years at that institution.



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Ms. Greenhoe is editorial secretary to *Michigan Medicine.*

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AMA seeks MDs' views of indemnification system of health care insurance

Here is the AMA proposal for an indemnification system for the payment of physicians' services. Could such a system replace the present UCR system of reimbursement?

What's your reaction?

Space is provided at the end of this article for your comments. Send them to John Richards, MSMS, 120 W. Saginaw St., East Lansing, 48823. Selected responses may be printed in a coming issue.

The AMA introduced a report at its Annual House of Delegates last June in Chicago outlining a new concept for the payment of physicians' services.

The AMA feels the present UCR system of reimbursement does not reflect what is actually a usual, customary or reasonable charge and that a system of indemnification would better serve the interests of the public, third party carriers and physicians.

The report of the AMA Council on Medical Service reviewed the present systems of payment for physician's services — fee-for-service, "capitation" and salary — with specific reference to problems resulting from the UCR system.

It was the recommendation of the Council that the payment system could be changed to an indemnity-based system for third party payment. An indemnification of payments would represent a schedule of allowances and not a maximum fee schedule. Therefore, it would allow the physician to charge the patient what the physician believes to be a fair and equitable fee.

The AMA Council also recommended that AMA delegates consider this issue with their constituents and other concerned parties over the next few months and be prepared to discuss this matter further at the interim meeting of the association in December.

Therefore, the MSMS Board of Directors and the AMA Delegation ask MSMS members to review this subject and provide reactions and comments. This topic will be discussed by the MSMS Board at the November meeting and also by various committees throughout the coming months. Below is a synopsis. If you wish copies of the entire report, please contact the Bureau of Economics.

Synopsis of Council on Medical Service Report, "Payment for Physicians' Services"

Present Association policy, which supports freedom of patients to choose their source of care and freedom of physicians to choose their method of payment — including fee-for-service, capitation, or salary — continues to appropriate.

Within the fee-for-service approach, current AMA policy supports the basing of third party payment levels on the "usual and customary or reasonable" concept, and the majority of private and public payors use the "UCR" concept in establishing payment levels. However, the increasing costs resulting from this approach have caused both private and public payors to be caught between mounting pressure to constrain plan outlays on the one hand, and continuing consumer demand for comprehensive coverage of physicians' services on the other.

As one result, the "reasonable charge" used by payors — particularly public payors — in determining payment levels no longer reflects the actual charges made by most physicians, because of infrequent updating of fee profiles, percentile cut-offs on customary charge data, and annual percentage caps on prevailing charge increases.

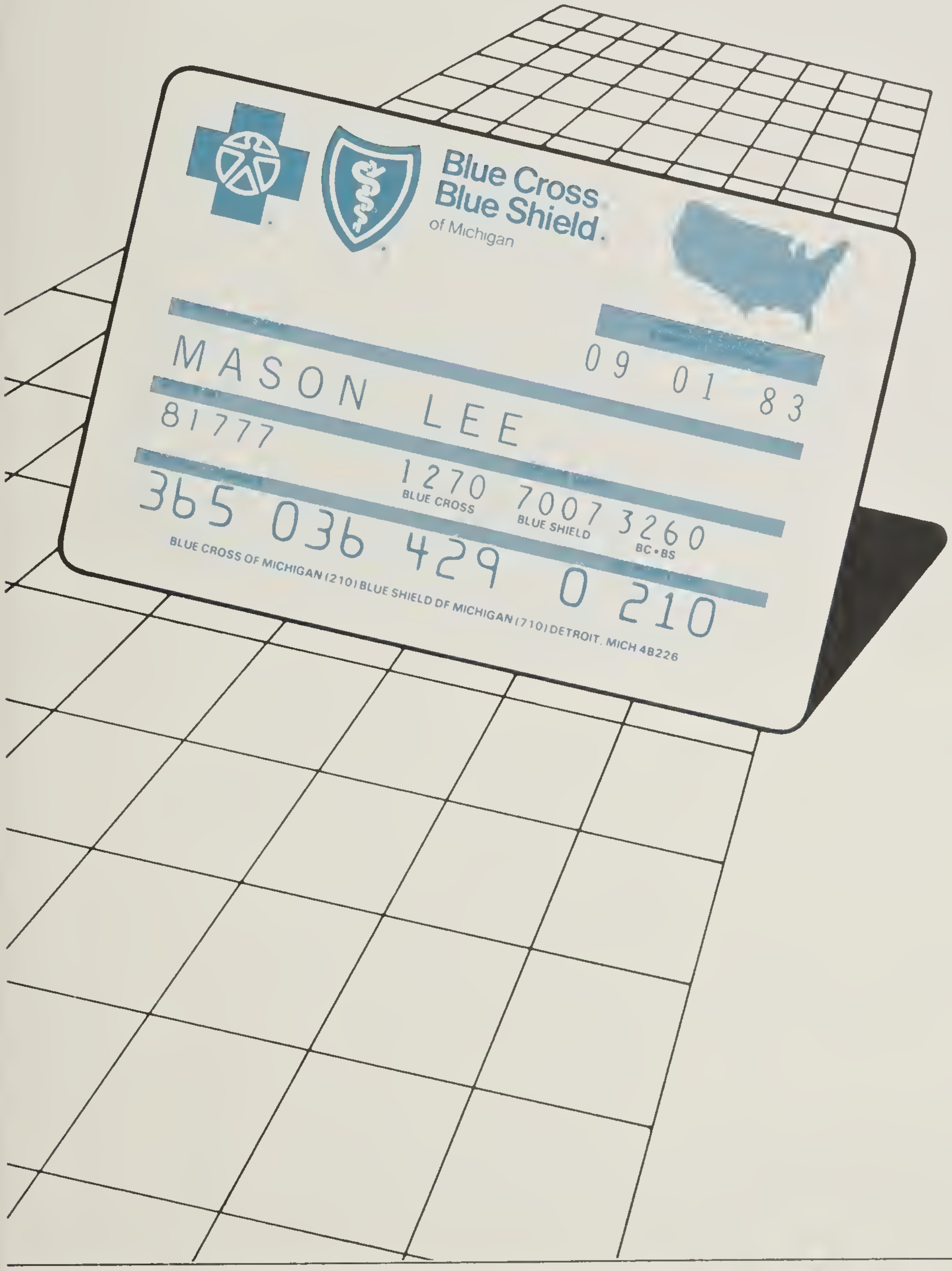
In addition, pressure is increasing on physicians to accept the payor-determined reasonable charge as payment in full (except for allowed deductibles or coinsurance) — i.e., to become "participating physicians." Such pressure is exerted through:

- Plan or company contracts which increasingly allow assignment of benefits or make payment only when services are provided by participating physicians;

Continued on page 592

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.



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Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan . . . a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $ 500 one person
$1,000 family

Dimension III for employees:
Deductible — $100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
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☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too?
For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

IT'S GOOD TO BELONG.

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INSURANCE/*Continued*

- Beneficiary misunderstanding of "explanation of benefit" letters and resulting patient/physician friction;
- "Hold harmless" communications from payors to subscribers, and
- Increased consideration nationally of mandatory assignment or fee schedules under Medicare.

As these trends continue, patients will be increasingly restricted to "participating" providers as a condition for insurance coverage. Eventually, physicians' remuneration will be determined solely by third party payors for the great majority, if not all, of the professional services they render — with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care.

Accordingly, the Council believes that the Association should seriously consider recommending that third parties change to an indemnity system of payment for physicians' services, i.e., paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, competition and other relevant factors.

Such a change would benefit patients by:

- Insuring their continued access to care not through external regulation of fees but through market forces;
- Increasing both physicians' and patients' sensitivity to costs and quality of care provided;
- Allowing them continued freedom of choice rather than being increasingly restricted to "participating" providers as a condition of coverage, and
- Facilitating understanding and comparison of insurance coverages.

For third parties, rate determination would be simpler under an indemnity approach. Payors could establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges. Administrative costs should be significantly less. For government programs especially it provides an alternative which permits budgetary restraints without further restrictions on type or duration of services covered or massive increases in enrollee copayment.

For physicians this approach could bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment. Uncoupling third party payment from physicians' charges could act to reduce legislative and political pressure for mandating physician "participation" as a condition of payment, and help preserve for physicians the freedom to charge what they believe to be a fair and equitable fee, subject only to normal and effective market constraints.

The Council believes that a change of this import in Association policy should be considered carefully by this House with their constituents over the next six months. The Council will also continue its study, and will submit recommendations at the 1983 Interim Meeting.

What do you think about the AMA proposal for an indemnification system of health care insurance?

Jot your comments here and mail to John Richards, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, 48823.

I agree/disagree with the concept. Here's why:

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Michigan's AMA Board chairman: 'meeting people always the most fun'

By Mert Scholten
East Lansing

"You have to like to read."

"A man on the move . . . and the move is ever upward" may well describe John J. Coury, Jr., MD, Port Huron general surgeon. Doctor Coury, current chairman of the Board of Trustees of the American Medical Association, holds the second highest AMA position ever attained by a Michigan physician. Soon he's likely to equal the rank held by Victor Clarence Vaughan, MD, Ann Arbor, AMA president in 1914.

In his office recently during a rare moment away from air travel on behalf of the AMA, Doctor Coury shared some of his feelings and his views for readers of *Michigan Medicine.*

'Guy next door'

Impressions one gets of John Coury are that he's a man who loves what he's doing, exudes unabashed leadership traits, and understands power. Though he admits to having a strong ego and moves among powerful people in medicine and politics, he strikes most who meet him as the guy next door.

Born in Wheeling, West Virginia, 62 years ago to parents of modest means, Doctor Coury has three brothers and one sister. Obviously, hard-working parents exerted a strong influence on their offspring. The sister is now a bacteriologist and three of the brothers are physicians — two general surgeons and one general practitioner. The other brother is vice-president of a large aluminum company outside Chicago.

"There were no doctors in our family tree until the three of us boys entered the profession," says Doctor Coury. "My mother nearly died of pneumonia when I was five. When she recovered, she was convinced that I was going to be a doctor; I guess that thought always stuck with me."

After finishing Washington and Jefferson College (Pennsylvania) in two and a half years, he went on to Case Western Reserve University, where he earned his MD degree in 1945. Following an internship at Detroit's Harper Hospital, service in the

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Mr. Scholten is MSMS chief of communications.

Doctor Coury on the issues

Reprinted from the Aug. 14 issue of the *Port Huron Times Herald.*

Doctor Coury's views on medical issues will be tested often during his term as board chairman of the American Medical Association.

Here is what he has to say about some of medicine's biggest concerns.

- Malpractice. "Medical liability is one of the major problems facing medicine today. The number and amount of lawsuits against doctors nationwide are frightening. And most of them are against doctors doing high risk work.

Doctor Coury said malpractice insurance for his office in Port Huron has increased 700 percent since he began practicing in 1951.

"It makes it a lot harder for young doctors just coming into practice. How can they afford it?"

- Ethics. Science increasingly is solving mysteries previously left to higher forces, he said.

"I did an operation recently on a 90-year-old man. Thirty years ago I couldn't have done that. He wouldn't have lived.

"There are many ethical questions that need to be answered today. When does a scientific advance become unethical? What do we do with deformed newborns? How far is genetic engineering going to go? When do we let a cancer patient die? They're not just decisions for the medical profession, but for everyone.

- Doctors' surplus. "There are warnings that we are producing a surplus of doctors. Teaching hospitals are having problems placing interns. Large cities are becoming glutted with doctors. The competition is having some positive effects, because the doctors are moving into smaller towns where they are badly needed.

"But the medical schools are going to have to decide if they want to cut enrollment or let the marketplace take care of itself. We believe the latter is best. If you produce good medicine, you'll survive as a doctor."

- Monitoring doctors. "It's essential that we police ourselves. We are continuing to do that with state licensing boards and we have made great strides with hospital review boards. All doctors must be held accountable within the profession for what they do."

"I hope we can keep a sense of sanity."

Army Medical Corps, and a residency, Doctor Coury began a general surgery practice in Port Huron.

Medical politics sought John Coury, not vice versa.

"The long-time MSMS councilor from our district chose not to run again and nobody else from the Thumb area wanted the job," Doctor Coury remembers. "As I was in a group practice, my senior partner decided that I should be our district's councilor. And that was it."

When asked about his role models, Doctor Coury quickly mentions past MSMS leaders Oliver McGillicuddy, Kenneth Johnson, Harold Hiscock and James Lightbody.

As the youngest member of the MSMS Council, Doctor Coury was instrumental in bringing about a bylaws change which limits to three the number of three-year terms a councilor (now district director) may serve. This change enables more physicians to serve in leadership positions, and makes it possible for younger doctors to enter key positions.

After 20 years of service to organized medicine (including eight years on the Michigan Medical Practice Board during which the state adopted a new medical licensing act) Doctor Coury feels well acquainted with medicine's problems.

"Someone has to handle the challenges and I like challenges," he says, explaining his motivation.

Like to read

One of the biggest challenges facing him is management of his own travel schedule.

"August was an easy month" — he was gone only 10 days. In September he could devote only five days to practicing medicine. He expected to be home just one week in October and maybe 10 days in November. He's looking forward to calling the last two weeks of December his own.

There are other demands of the job.

"If you're going to be involved in medical politics, you've got to like to read," he says. For the April AMA Board of Trustees meeting, for in-

Continued on next page

COURY/*Continued*

"I am proud to represent Michigan physicians."

stance, he had to read a one and a half foot high stack of reports weighing more than 30 pounds. The AMA job requires an average of one to two hours per day of reading.

And then there are the multiple daily phone calls with AMA executive committee members, staff and other board members. Despite them all, Doctor Coury maintains his unflappable manner and concern for patients.

What does he see as the biggest problem facing organized medicine? Doctor Coury responds, "I hope we can keep a sense of sanity through the competition now evolving among hospitals, physicians, government and all combinations thereof."

Other problems include the cost of care, professional liability and the various threats to quality of care. Maintaining the quality of care is one of the main roles physicians must play today, he says. "It is a real shame that out of all the confusion surrounding health care today we are seeing an increase in cost and potential lowering of the quality of care among the buying forces.

"We physicians are the only true patient advocates and we need to make sure that quality and continuity of patient care are maintained. If we don't do it, no one else will," Doctor Coury exclaims.

As a results-oriented person, Doctor Coury looks forward to working for the cause of organized medicine where he says "meeting people" is the most fun and "always has been."

No better person

Those who know him best are betting on John Coury to accomplish his goals. As Joe Barss, MD, his friend and partner for more than 30 years says, "If John ran for President of the US, all of us would vote for him, even if it meant having to cover for him full-time in his practice."

"As partners, we're glad to pick up the load. We're happy that he's able to do what he's doing for organized medicine as well as himself. He's earned it and there's not a better person for the job."

Doctor James Gerrits of St. Clair, who has had philosophic differences over the years with Doctor Coury, wrote recently to the editor of the *Port Huron Times Herald*. "The American Medical Association could go far and not find a better man than John Coury for spokesman and heir-apparent to the presidency. Always pleasant and cheerful, he has that rare quality of disagreeing if he has to, but obviously striving to accommodate the opposite point of view (and usually succeeding in at least a compromise). . . . An accomplished doctor, a fine human being and a refreshing new image for the AMA."

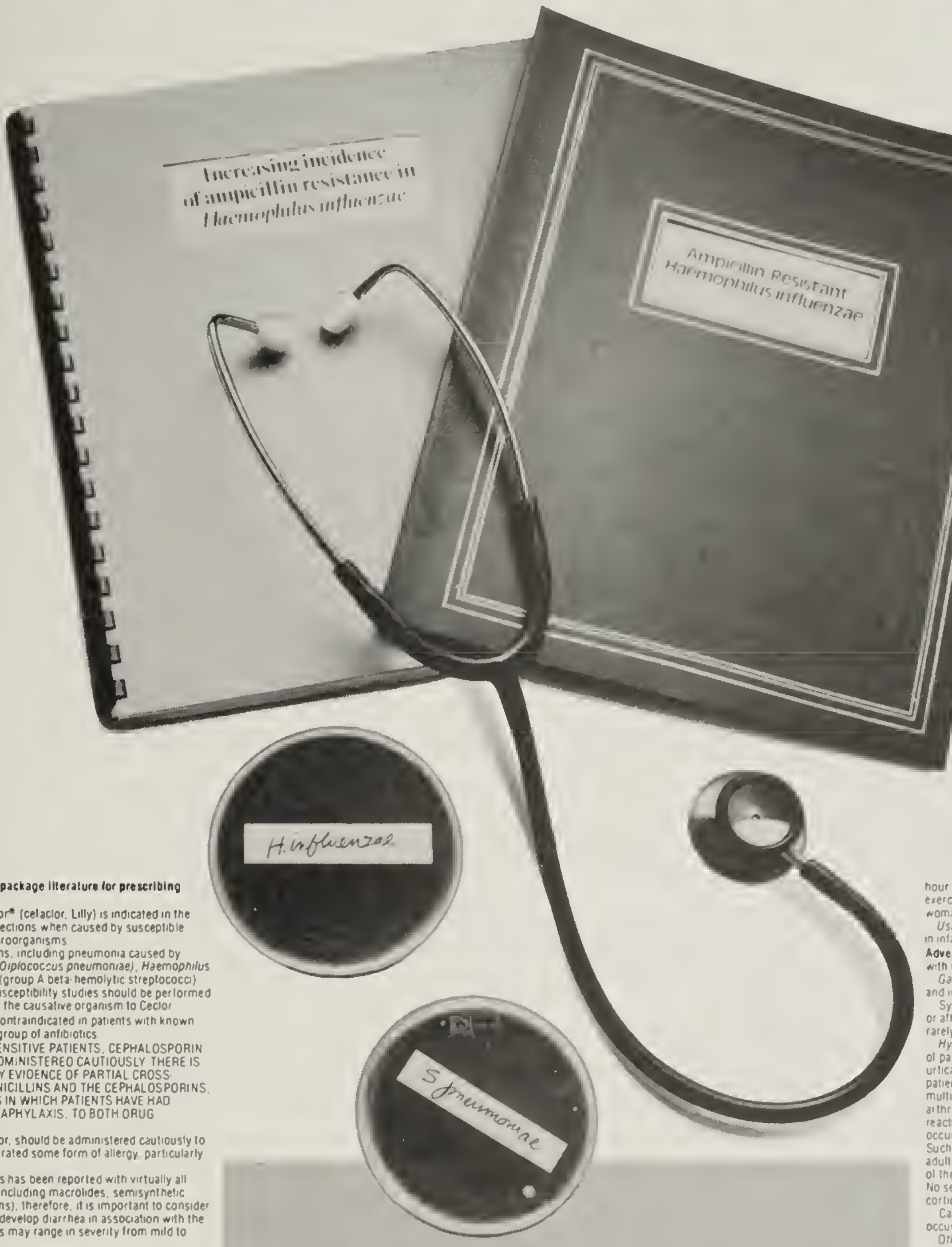
Doctor Gerrits' letter echoes commonly heard praise for Doctor Coury. "You don't find people much finer than John Coury," said Frank Andreoni, Michigan Bank Port Huron president in a recent story in the Port Huron paper.

When asked to point to highlights of his career, Doctor Coury, without hesitation, says, "There are so many involving patients. The greatest reward for any physician is seeing a patient through a very difficult or life-threatening problem and getting a good result. That's still what makes it all worthwhile."

Doctor Coury looks to his inauguration as MSMS President 11 years ago along with his election and reelection to the AMA Board of Trustees as the outstanding moments in his medical-political career.

"It is an honor to be elected when you know there are others who could do the job and perhaps do it better. But it gives you tremendous incentive to do your best for those who've put their faith in you," says Coury. "Above all, I am proud to represent Michigan physicians. I will do my utmost not to let them down."

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus Influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and S *pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued and, if necessary the patient should be treated with appropriate agents, e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21 and 0 16 mcg ml at two three four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria and positive Coombs tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis-arthralgia and frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT SGPT or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either S *pneumoniae* or *H influenzae* [8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections including the prophylaxis of rheumatic fever See prescribing information

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Ford's salaried employees now have copay insurance coverage

MSMS members for years have advocated health care insurance programs with co-pay and/or deductible structures, to help reduce the cost of the insurance, and to instill some responsibility for costs on the individual.

In keeping with this belief, MSMS health insurance programs offered to members and their employees include a co-pay and deductible plan.

Recently, the Ford Motor Company replaced its comprehensive medical plan for salaried (non-UAW) employees with a new model which includes a deductible co-payment feature.

In the August 5 employee bulletin, Ford described the new plan as follows. *Michigan Medicine* reprints the pertinent parts of the bulletin here as an example of one co-payment plan in operation close to home:

"... the Company continues to be greatly concerned about the rapidly increasing cost of health care. The company's 1983 health care cost is expected to average $2,818 per participant, almost double the 1978 average cost of $1,469.

Over the same five-year period, the cost of health care per vehicle produced increased to $338 in 1983 from $130 in 1978, an increase of 160 percent. In recent years, several cost containment actions have been introduced, but much more needs to be done to slow down appreciably the high rate of increase in health care costs. With this in mind, the salaried

Continued on page 600

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FORD BENEFITS/*Continued*

health care programs have been restructured to provide greater individual incentives to control these costs.

Comprehensive Medical Plan (CMP)

Effective January 1, 1984, a new comprehensive medical plan will replace the present basic, supplemental and extended medical benefit plans. With some exceptions, this new plan will pay 80 percent of reasonable and customary charges for all covered services after an annual deductible of $200 for an individual or $250 for a family has been met. Once the employee's out-of-pocket expense for all family members has reached $750, however, the plan will begin reimbursing 100 percent of the covered expenses. Under the new plan, the employee's protection against catastrophic medical expenses has been improved. The present limit of 365 days of hospital care per confinement and the annual and lifetime maximums on extended benefits have been eliminated.

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Beginning in 1984, 80 percent of physicians' reasonable and customary office charges will be reimbursed beginning with the first visit. This change is particularly important for employees with only routine medical expenses. They will no longer need to meet a deductible to receive reimbursement for part of the cost of these visits.

In addition to office visits, other categories of medical expenses will be handled outside the overall plan deductible, and are subject to different co-payments and maximum liability limitations:

1. Private-duty nursing at home will be paid at 50 percent of reasonable and customary charges with no deductible.

2. Certain foot surgery (skin, nail, soft tissue and serial surgery) will also be paid at 50 percent of reasonable and customary charges with no deductible.

3. For psychiatric and substance abuse treatment, reimbursement for *out-patient care* will be 100 percent of charges for the first five visits, 75 percent for the next five, and 50 percent thereafter until the extended illness provision, below, applies. Charges for *in-patient care* are reimbursed the same as other illness for the first 30 days. Therefore, 80 percent of in-patient expenses will be paid by the company regardless of the general plan limit on out-of-pocket expenses. As a protection against extended illness, out-patient and in-patient care for both psychiatric and substance abuse treatment will be reimbursed 100 percent after employee costs exceed $5,000 annually. There will be no reimbursement under the new plan, however, for psychiatric and substance abuse out-patient treatment in excess of a lifetime maximum of 140 visits.

Under the new plan, charges for services not medically required will no longer be covered. These include hospitalization related to elective cosmetic surgery and charges for certain services and equipment. Non-prescription medication and reimbursement of drug plan deductibles also will no longer be covered. The Prescription Drug Plan, including the new mail order feature, and hearing and vision care benefits remain unchanged.

Employees who incur charges under the present extended benefit program during October, November and December 1983 that are applied toward meeting the 1983 deductible limits will be able to have these charges carried over into 1984 where they will be applied toward meeting the 1984 deductible limits, but not the $750 maximum employee liability. This will be a one-time transition feature.

Administration of the CMP

". . . With the introduction of deductibles and co-payments for most health care, the method of claim payment will be modified. There will be a procedure for participating providers — hospitals, physicians, laboratories, etc. — to continue to submit bills directly to the appropriate plan administrator (the local BC-BS plan or John Hancock). The local BC-BS plan or John Hancock will reimburse the provider up to the full reasonable and customary charge. Employees will then be notified of the portion of the charges that is their responsibility and how it may be paid.

Health Maintenance Organizations (HMOs)

HMOs will continue to be available as an alternative health care arrangement. These plans offer an opportunity for medical care with little or no out-of-pocket cost. Generally, HMO plans do not have deductibles and co-pays and offer "first dollar" coverage. Presently, salaried employees are offered enrollment opportunities in 20 HMOs in 16 locations. There are plans to increase HMO availability, especially in areas where employees do not now have an HMO option. During the general enrollment period this Fall, employees will have a choice to enroll in an available HMO or the Comprehensive Medical Plan.

Many HMOs are expected to be available at no cost to employees. There will be a premium required, however, if the cost of the HMO is higher than the cost of the new Comprehensive Medical Plan. The premium rates for 1984 will be available in September 1983. However, based on 1983 costs, there would be no charge for several major HMO plans and rates ranging up to $12 per month for single coverage with $33 per month for family coverage for the others. HMO premiums, if required, will be payroll deducted.

Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of the unique benefits of

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For a summary of product information, please turn the page. ROCHE®

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Valrelease™ (diazepam/Roche) ⒸⅣ slow-release Capsules
Injectable Valium® (diazepam/Roche) ⒸⅣ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> *Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins,* i.e., *dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL. Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500, Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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MDs might as well form PPO reception line

By Robert Asmussen
Detroit

The following are highlights of a talk delivered at the MSMS Board of Directors' Midsummer Meeting at Boyne Mountain. In his talk, Mr. Asmussen supported the MSMS board's plan to keep MSMS members informed about the preferred provider organization (PPO) concept. The following article is printed in that spirit.

Mr. Asmussen is senior consultant with Henry Ford Hospital. He formerly was vice president of medical affairs for Blue Cross Blue Shield of Michigan.

What is a PPO?

Very simply, it is an organization under which hospitals and physicians agree to deliver a specified set of health services at negotiated prices, and consumers in turn are offered financial incentives to use preferred providers.

This is not a new concept. You have been dealing with PPO since 1939, namely Blue Cross Blue Shield of Michigan. It has differentiated between par and non-par in terms of its benefit structure. What is new and different about PPOs today is that they are talking about limiting access.

Why is there such a lot of talk about PPOs? It's because organizations, and particularly employers, are tired of the cost of the traditional fee-for-service system. Also, they are disappointed in the election rate of employers for HMOs. They are looking for some alternative short of HMOs which will deal with the health care cost question.

On the other hand, physicians and hospitals are comfortable with

Continued on page 604

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the traditional fee-for-service system, are not prepared to accept the HMOs as the single delivery system, and, as a result, are looking for some in-between position that retains the fee-for-service concept but also makes a major commitment to cost containment. Thus, PPOs get a lot of attention.

I do not want to suggest that the concept is all that simple. In terms of design, PPOs go all the way from nearly traditional fee-for-service structures, through loosely affiliated relationships with a promise to contain costs, to a capitated PPO which differs from an HMO only in name.

Common characteristics of all PPOs are reduced access; a defined, selected list of providers and professionals; a contractual relationship between the provider and the payor, and negotiated rates, usually discounted.

A significant component in structuring a PPO is the utilization control mechanism. Unless a PPO has one it might as well forget any long-term life in the business.

Faddish

In my opinion the health care delivery system is very faddish. We all get excited about new and different things. It sounds like PPOs might be the best thing since sliced bread. But there are significant difficulties and I think it is important to keep those in mind, particularly as they relate to Michigan.

There are serious legal and anti-trust problems related to PPOs unless they are structured to avoid such problems. Just as important as structuring to ultimately win on anti-trust grounds is to structure to avoid lawsuits in this arena. There are a lot of people who are selling their services in the legal world advising PPOs. But the fact is there is no legal language applicable to PPOs at this time and there won't be until lawsuits work their way through the courts on this concept.

It is particularly important that employers be willing to restructure benefits to provide an incentive to their employees to utilize the PPO. A lot of employers I talk to are very interested in PPO, but at the same time they are not really interested in reducing the benefit level of traditional fee-for-service. If you want to encourage PPO and HMO selection you obviously have to reduce first dollar coverage in traditional fee-for-service arrangements.

From a consumer point of view I think we are spoiled, particularly in Michigan. We have absolute access to quality care. For most of us it has been first dollar coverage, so it's nothing out of pocket. All of a sudden this new thing comes along that says that our access is going to be limited and that we cannot pick and choose our doctors and hospitals as we have historically. So for us it is also a disciplinary kind of problem. Acceptance of the philosophy is not going to be easy.

The important thing is that if a PPO is going to be successful it must demonstrate to an employer that there is a network of professionals and hospitals constituting the PPO which deals with this historical consumer desire for convenient access to care.

Continued on page 606

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PPOs/*Continued*

Critical

Will the PPO really achieve the cost savings it sets out to achieve? Bear in mind that most will continue the fee-for-service payment system with its inherent weaknesses in terms of financial incentives on the professional provider world.

So the utilization program of the PPO is absolutely critical to making it work.

The only way the utilization rate can be controlled in a PPO is through a very carefully structured program. And even if you do well the first year, will that momentum continue? And do you have data systems and discipline within the PPO to make sure the utilization performance continues to be good?

Key to the utilization program is the gatekeeper strategy. Primary care physicians, however identified, must control and manage the care of the patients within the preferred provider organization.

There are other kinds of utilization controls you can put in the program that are not new: pre-authorization, second opinion surgery, pre-admission testing, better discharge planning. All of these programs can be a part of the package and enhance the ability of the PPO to deliver in terms of utilization control.

There are all kinds of sponsorship alternatives for PPOs: hospitals-single or network, physician groups, hospital/physician joint ventures, payors and entrepreneurial types. I think the joint venture arrangement has the best opportunity for success in Michigan because it creates a close working relationship between private practitioners and hospitals.

For a hospital to do a PPO alone and attempt to generate the kind of support from the physician staff that is required is extremely difficult. Likewise, I think it is equally difficult for physicians on their own to create a PPO and then have to deal with hospitals as outsiders. So why not think about a joint venture, given the future of Medicare and DRGs, and the need for hospitals and doctors to communicate and work together better?

A joint venture offers an opportunity not only to make the DRG system work, but also to enhance PPO success. If a hospital sponsored a PPO, it would expect the doctor to reduce health care utilization and reduce his or her fees, while the hospital continues on with stable and increasing income. A joint venture causes the hospital to commit to productivity and price controls just as the physician is committed to reduce the use of service within and outside the institution.

These joint ventures can be structured as non-profit or for-profit enterprises. I encourage for-profit, because it adds a dimension of control and discipline to both hospital and physician ownership.

Membership can be selective or open to the entire medical staff. If it is open, I think it is particularly important that the eligibility criteria be clearly outlined, with an annual review to assure that the PPO is satisfied with performance. Ownership can be like a golf club, with a sub-

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I think you need an incentive pool, perhaps developed by retaining 10 percent of the fee-for-service income. It then can be distributed at the end of the year based on the cost containment performance of the individual members in the program. I also think it would be desirable to negotiate with the employers themselves some sharing of the cost savings generated from the performance of the PPO.

Favorable

How does it look for Michigan in terms of development of the PPO concept? I think the environment is very favorable.

You find a lot of competition with HMOs as well as providers losing market share, particularly in Southeast Michigan. There is an over supply of health care resources both in terms of physicians and hospital beds. Michigan experiences a very high rate of utilization, particularly on the inpatient side, and employers are getting dead serious about alternatives. We are seeing some evidence that they are indeed going to make changes in terms of the traditional first dollar fee-for-service package.

So it behooves the health care delivery system to organize to be receptive to the PPO kind of delivery system.

The largest company forcing change in health care benefits is Chrysler. They tried in the last round of negotiations to develop a PPO alternative. They ran out of negotiating time to develop something, but the Chrysler management has not given up.

In a new publicity campaign with their employees they talk about the seriousness of the health care cost problem, its impact on the economy in general, and its impact on their wages and salaries. They then hint at the solution: reduced access to care and alternative kinds of delivery systems.

Just last week Wayne State University issued a letter to employees. In the Wayne State case, employees will pay $100 per month out of their paychecks to retain traditional Blue Cross Blue Shield coverage; they likewise endorsed a number of HMOs. We are going to see more and more of that, particularly among employers who do not have the collective bargaining difficulties that the big three and other UAW organizations have.

It is very clear to me that PPOs are going to become a reality in Michigan. Just how long they will prevail and how big the PPO delivery system will become, remain to be seen. But I think it makes good sense for the professional population of the state to be receptive to new delivery systems.

It also is necessary to protect the delivery system and avoid the kind of legislative effort of the Blues at the moment which would give them "carte blanche," monopoly power to, in effect, carve up the delivery system as they see fit.

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 4-5 — "Medical Control and Accountability in Emergency Medical Services," Marriott Hotel, Chicago, cosponsored by the AMA Commission on Emergency Medical Services and the American Hospital Association, contact: Department of Health Care Resources, American Medical Association, 535 N. Dearborn Street, Chicago 60610 (312) 751-6433.

Nov. 4-5 — "Fall Festival of Knowledge," Fall Leadership Seminar, American Association of Medical Assistants, Michigan State Society, Sheraton Fashion Square Hotel, Saginaw, contact: Caroline Rich, MSMS headquarters.

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Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Feb. 4-5, 1984 — "Through the Looking Glass," American Association of Medical Assistants, Michigan State Society, Mid-Winter Seminar, Amway Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

March 29, 1984 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

April 26-29, 1984 — Annual State Convention, American Association of Medical Assistants, Inc., Michigan State Society, Lansing Hilton Inn, contact: Caroline Rich, MSMS headquarters.

Other meetings

Oct. 24-27 — "Emergency '83," 1983 Scientific Assembly, American College of Emergency Physicians, Georgia World Congress Center, Atlanta, contact: ACEP, (214) 659-0911.

Nov. 9-13 — 68th Annual Meeting of the American Medical Women's Association, Hyatt Regency, Dearborn. Keynote speaker: MSMS President Donald Crandall, MD. Contact: AMWA, 465 Grand Street, New York, 10002 (212) 533-5104.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 13 — Leadership Workshop for Foreign Medical Graduates, Hyatt Regency, Dearborn. Conducted by the American Medical Women's Association Professional Resources Research Center. Contact: Sue Earley, AMWA PRRC, 2302 E. Speedway, #206A Tucson, AZ 85719-4794, (602) 795-2677.

Nov. 30 — "AIDS: The Facts and the Issues," Engineering Society of Detroit, cosponsored by the Venerea Disease Action Coalition and Wayne County Medical Society, contact (313) 833-0622, ext. 54 or 29.

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cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofurantoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

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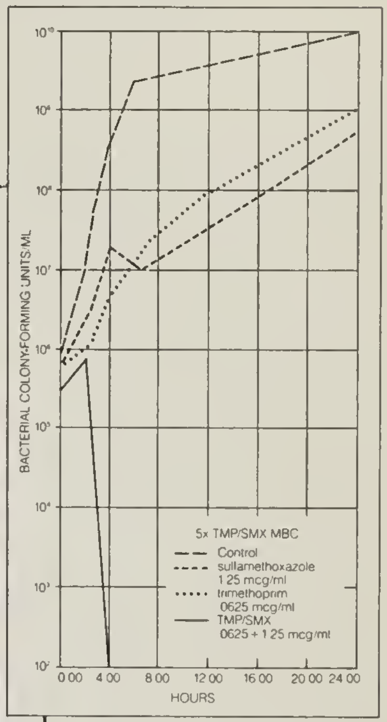

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See next page for references and a summary of product information.

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J *et al: Rev Infect Dis 4*:562-565, Mar-Apr 1982. **4.** Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. **5.** Ronald AR: *Clin Ther 3*:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother 6*:231-239, 1980. **7.** Gower PE, Tasker PRW: *Br Med J 1*:684-686, Mar 20, 1976. **8.** Cosgrove MD, Morrow JW: *J Urol 111*:670-672, May 1974. 9. Iravani A *et al: Antimicrob Agents Chemother 19*:598-604, Apr 1981. **10.** Schaeffer AJ, Flynn S, Jones J: *J Urol 125*:825-827, Jun 1981. **11.** Rous SN: *J Urol 125*:228-229, Feb 1981. **12.** BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS
(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: *Not recommended for infants less than two months of age.*
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Nutley, New Jersey 07110

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Barton Brown
Assistant Treasurer

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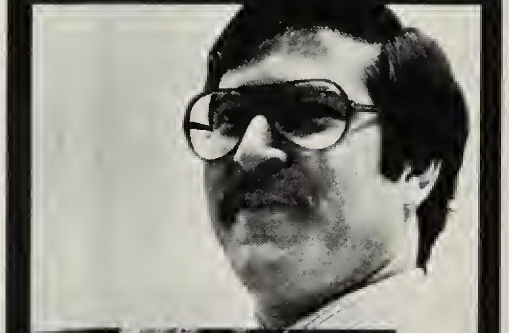

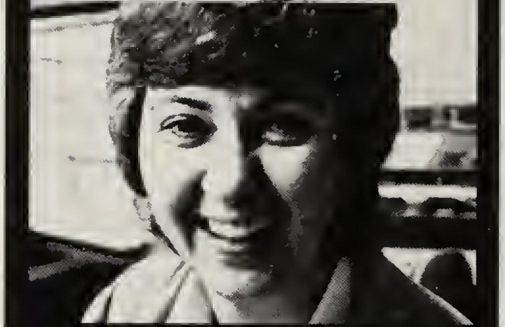

Kay Smith
QC Tester & Inspector

"When my husband and I got married, we paid for our wedding with U.S. Savings Bonds my grandparents gave me when I was born. Now I buy U.S. Savings Bonds because they are the only way I can really be sure I'll have money for my 14 year old daughter's education. It's a safe way for me to save because I'm not as tempted to cash in my bonds as I would be to spend cash."

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An open letter to all physicians' spouses

Re: Membership in the Michigan State Medical Society Auxiliary
From: Barbara Grennan, MSMS/A member-at-large coordinator

We hate to admit it, but our membership has decreased in the last few years.

There has been a growing number of resignations which has not been offset by the enrollment of new members. While there has been a steady increase of practicing physicians and a growth in the Michigan State Medical Society to over 10,000 members, there has been a declining pattern of auxiliary membership to our present low of 2,335 members.

Why this large disparity exists we can only guess. Some conclusions are that older members withdraw to relocate elsewhere; there are more working spouses with less time and inclination for active involvement, and others have a strong reluctance to accept the so-called "doctor's wife" title or role.

Reach out

One other reason may be our inability to reach every potential member of MSMS/A in areas of the state that have no organized auxiliary. There they may not even know of our existence!

For whatever reason, there are many persons who could, but do not, belong to our auxiliary. We want to reach out to tell them who and what we are and to persuade them to join us.

Ours is a service organization. We have access to and use programs of the American Medical Association Auxiliary, as well as programs of our own. We have publications like MSMS/A's *AUXILIUM* and the AMA Auxiliary's *FACETS,* which deliver information on auxilians' activities in Michigan and the rest of the country. We engage in fund raising for AMA/ERF (American Medical Association Education and Research Foundation). This past year we earned $1.85 million for scholarships and loans for medical-related careers and for community-oriented medical projects.

The increasing emphasis on volunteerism presents us with even more opportunities for community service projects. Our strengths lie in areas related to the general sphere of medical practice. We can promote programs on parenting, child abuse, alcohol and drug abuse, teenage pregnancy prevention, drunk driving legislation and coping with stress. In the words of Glenda Bates, president of the AMA Auxiliary, "The auxiliary is the medical profession's greatest public relations strength. We are the medical profession's ambassadors to the community and public."

We care

We are a caring organization — sharing our time, talents and resources to provide community leadership in health-related activities. Our role is sometimes thankless, many times more time-consuming than planned, but always rewarding when we see a goal reached.

Auxiliary members have something in common — marriage to a medical professional. We ask our members to support that commonality by inviting others to join the Michigan State Medical Society Auxiliary.

Please use the form below to help others indicate their interest in MSMS/A. Dues are $20 per year ($5 state/$15 national), a small sum for full membership in an organization for, by and of physicians' spouses. WIN OVER A NEW MEMBER TODAY!

- - - - - - - - - - - - - - - - - - - -

_____ YES! I am interested in membership in the Michigan State Medical Society Auxiliary.
Enclosed is my check made payable to MSMS Auxiliary for $20.00

Name ______________________ Spouse's Name ______________________

Address ____

____

Telephone Number ( ) ______________________

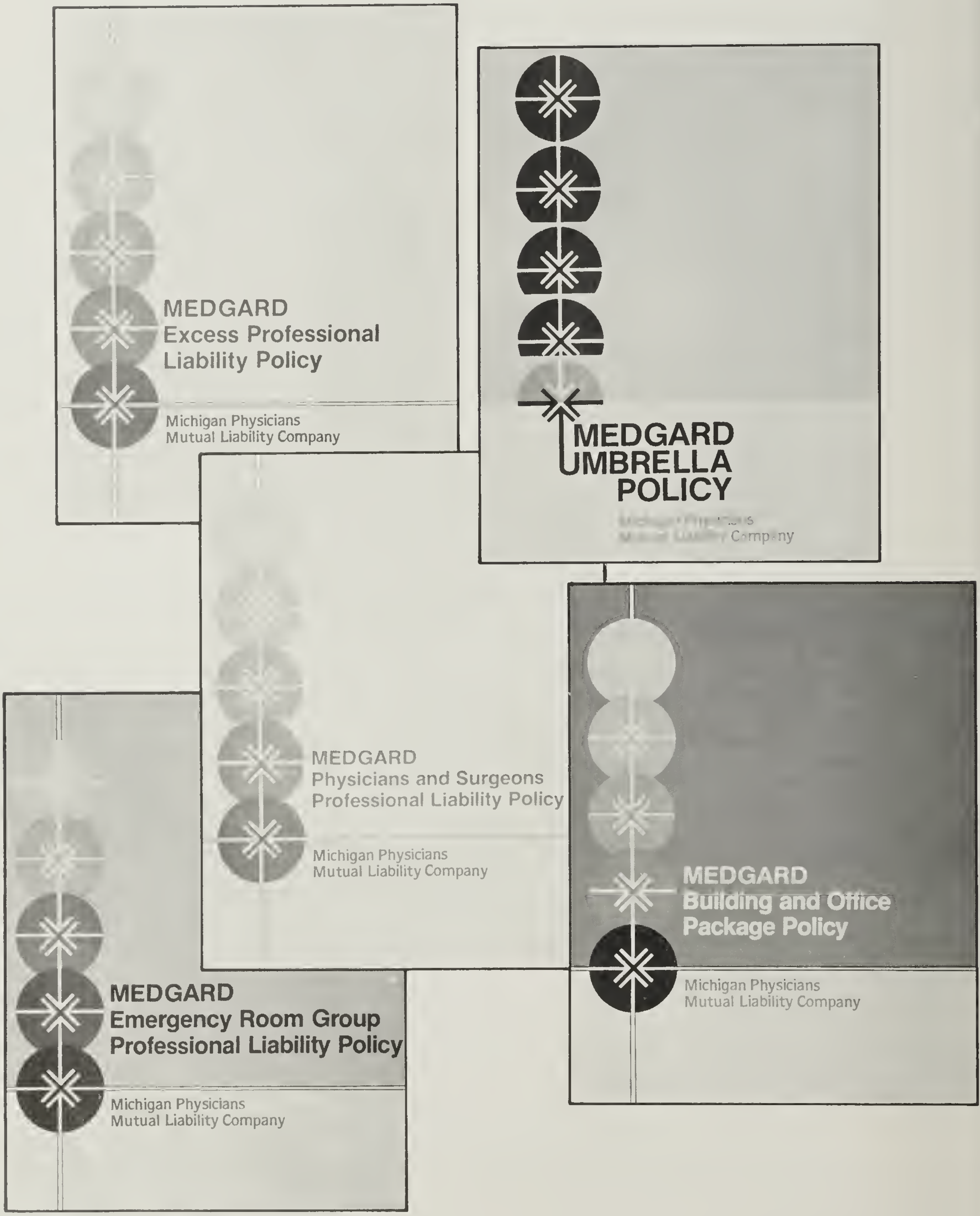
County ______________________

_____ Please send me additional information about MSMS/A.

_____ Please send me information about organizing a county auxiliary

Mail to: MSMS/A
P.O. Box 950
East Lansing, Michigan 48823

WHAT YOU SEE.



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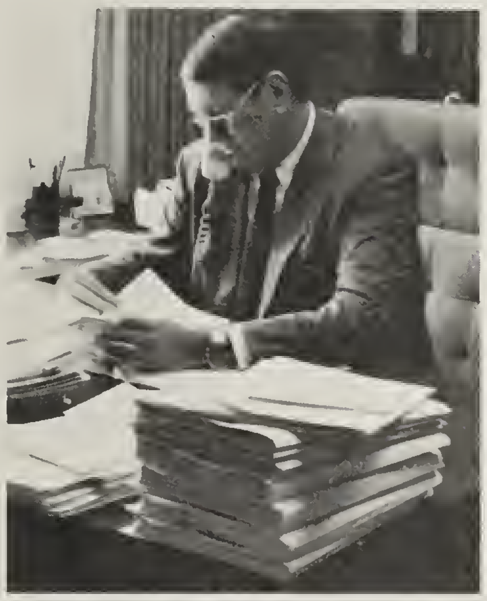
AND WHAT YOU GET.



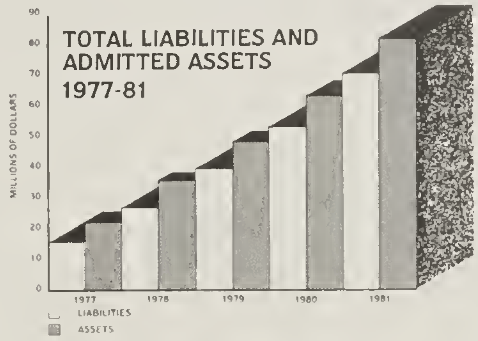
Service. Claims service is what you buy a professional liability policy for in the first place. Our policies are backed by the most experienced professional liability claims staff in Michigan. Our claims representatives return your phone calls and keep you informed of the progress of any claim in which you may be involved. These professionals and the excellent defense attorneys assigned to represent our policyholders have helped Michigan Physicians build our excellent reputation for claims services.

Michigan Physicians
Mutual Liability Company
Claims Information Kit

Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our in-house computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

Stability. Assets of over $88 million back our policies. That's more than $20,000 for each physician insured with us for primary, professional liability. Total surplus of $11.4 million is further evidence of our financial strength and stability. In other words, our policyholders have $3 of equity for every $4 of net premium that we write annually.



Leadership. Our leaders are also your leaders. They have responded to your professional liability needs. Two years ago physicians came to us and wanted higher limits. We were the only company in Michigan to offer $1 million dollars in primary coverage to physicians in 1980. When physicians asked for excess and umbrella coverage last year, we responded with two, new policies that added the additional limits they requested. Michigan Physicians' leadership has introduced insurance products designed to meet your requirements...and lead the state with outstanding coverage for physicians.

Endorsement. We are the only professional liability company endorsed by the Michigan State Medical Society. The support of MSMS has helped our company grow from an idea in 1975 —to Michigan's leading physician insurer. We value our relationship with the members of MSMS and we are proud to display their official seal.

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Famous Pairs.

The Columbia space shuttle was a triumph of teamwork. And along with Young and Crippen went Anusol-HC Cream to treat prior anorectal conditions aggravated by "G-Force" stresses of exiting and reentering the earth's atmosphere.

Anusol-HC® & Tucks®

...another well-known pair that work so well together! Ninety-five percent of colon/rectal surgeons surveyed added Tucks pads concomitantly to hemorrhoidal treatment programs.*

Anusol-HC®
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription
1 oz (28.4 grams)
ANUSOL-HC
ULL APART
TUCKS®
Pre-Moistened Hemorrhoidal Vaginal Pads
PARKE-DAVIS
40 PADS

Anusol-HC®
Suppositories / Cream
with Hydrocortisone Acetate

*The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders***

- ☐ *Antiinflammatory, to relieve itch, pain, and edema.*
- ☐ *Astringent, to protect against further tissue damage.*
- ☐ *Emollient, for easier bowel movements.*

Please see opposite page for brief summary of prescribing information.

And, when pain is a special problem, Anusol® Ointment offers the benefits of the topical anesthetic pramoxine HCl.

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads

*The #1 hemorrhoidal** pad for added external relief and gentle cleansing.*

- ☐ *Soothes, cools, comforts, and cleanses irritated anorectal areas.*

Once pain and inflammation subside, for dual action recommend regular ANUSOL® and TUCKS.®

**Meeting of Am Soc Colon / Rectal Surgeons, May 1980*
***Data on file, Marketing Research Dept, Parke-Davis*
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PD-85-JA-1336-P-1(11-82)

PARKE-DAVIS
Div of Warner-Lambert Co
Morris Plains, NJ 07950

TUCKS®
Pre-Moistened Hemorrhoidal/Vaginal Pads

Hemorrholds and other anorectal uses — TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witch hazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%, benzyl benzoate, 1.2%, Peruvian balsam, 1.8%; zinc oxide, 11.0 mg, also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy: See "WARNINGS".

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
1089G010

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: October 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand and the International Federation of Societies for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Bldg., 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 1-3, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education. The Towsley Center, U-M, Ann Arbor 48109, (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: November 2, Infectious Diseases Symposium. Location: Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** CME Department, Butterworth Hospital. **Cost:** $15. **Contact:** Celia M. Steele, Conference Coordinator, (616) 774-1835. **Approved for:** 4 hours of Category I Credit.

Date: November 2, 23rd Annual Thyroid Workshop. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** Division of Endocrinology, Department of Internal Medicine, WSU. **Contact:** (313) 577-1180. **Approved for:** 6 hours of Category I Credit.

Date: November 2, Update on Antiarrhythmic Agents. Location: Henry Ford Hospital Education and Research Building. **Sponsor:** Henry Ford Hospital. **Contact:** AFH Medical Ed. Office, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 6.25 hours of Category I Credit.

Date: November 4-5, Multimodality Therapy for Head and Neck Cancer: A Model for the 80s. Location: Hyatt Regency, Dearborn. **Sponsor:** Radiation Oncology Center, Harper-Grace Hospitals. **Contact:** Don Ragan, PhD, Radiation Oncology Dept., WSU, 4201 St. Antoine, Detroit 48201, (313) 494-9207. **Approved for:** 8 hours of Category I Credit.

Date: November 4-5, Fifth Annual Critical Care Seminar. Location: St. Mary's Hospital, Saginaw. **Sponsor:** Saginaw Cooperative Hospitals, Inc. **Cost:** $100. **Contact:** Hospital Education, St. Mary's Hospital, Saginaw (517) 776-8400. **Approved for:** 12 hours of Category I Credit.

Date: November 10-11, Third Annual Clinical Oncology Course. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: November 11-12, Fourteenth Annual Symposium on Trauma. Location: Kresge Auditorium, Harper Hospital, 3990 John R, Detroit 48201. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Chapter, American College of Emergency Physicians; Wayne State University Department of Surgery. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 9 hours of Category I Credit.

Date: November 12, Borderline Patients: Psychoanalytic Perspectives. Location: The Michigan Inn, Southfield. **Sponsor:** Michigan Psychoanalytic Society. **Cost:** $60. **Contact:** Michigan Psychoanalytic Society, 16310 W. Twelve Mile Rd., Suite 204, Southfield 48076. **Approved for:** 6 hours of Category I Credit.

Date: November 13, Sixth Annual Pediatrics Conference. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, MI 48824, (517) 353-8822. **Approved for:** 6.5 (applied for only) hours of Category I Credit.

Continued on page 619

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31st ANNUAL SYMPOSIUM ON TRAUMA

November 11-12, 1983

Kresge Auditorium
Harper Hospital
3990 John R
Detroit, MI 48201

Guest Speakers

Frank B. Cerra, MD
Donald E. Fry, MD
Kenneth L. Mattox, MD
J. David Richardson, MD
H. Harlan Stone, MD
Donald D. Trunkey, MD

Course Director: Robert F. Wilson, MD

Registration fee:	$95.00 Practicing Physicians $50.00 Physicians-in-training and other health care professionals
Sponsored by:	Wayne State University School of Medicine Michigan Committee on Trauma, A.C.S.
CME credit:	9.5

For further information, contact: Theresa Sokol; WSU, Department of Surgery; 6-C UHC, 4201 St. Antoine; Detroit, MI 48201; (313) 577-5009

CATEGORY I/*Continued*

Date: November 25-29, **8th Annual Ophthalmology Basic and Clinical Review Course. Location:** Hyatt Regency Hotel, Dearborn. **Sponsor:** Kresge Eye Institute of Wayne State University. **Contact:** (313) 577-1180. **Approved for:** 44 hours of Category I Credit.

Date: December 3, New Developments in the Diagnosis and Treatment of Anxiety Disorders. Location: Hotel Pontchartrain, Detroit. **Sponsor:** Brain Research Fund of Michigan, Department of Psychiatry, WSU. **Contact:** (313) 577-1180. **Approved for:** 6 hours of Category I Credit.

Date: December 3, Michigan Short Stature Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: December 5-9, Basic Principles of Manual Medicine. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents lectures, demonstrations, and practice sessions on the spine, pelvis, and extremities. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: December 10, December Seminar, Michigan Society of Pathologists. Location: Rackham Auditorium, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: February 11, 1984, February Seminar, Michigan Society of Pathologists — "Quality Control in the Clinical Laboratory." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists in cooperation with the Great Lakes Regional Quality Control Program. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint 48503. **Approved for:** 3 hours of Category I Credit.

Date: March 17-24, 1984, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Continental Inn, Aspen, Colorado. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 30 hours of Category I Credit.

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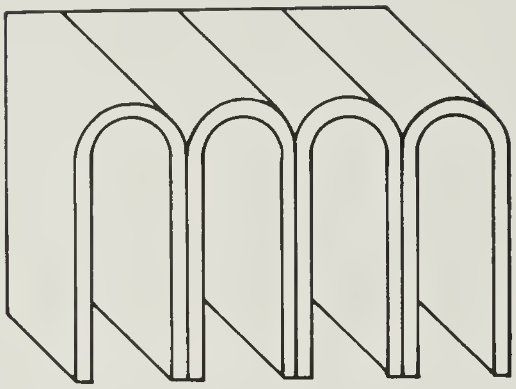

John P. Bremer, MD
East Detroit

John P. Bremer, MD, East Detroit, died May 1. He was 60. Doctor Bremer, a Detroit native, earned his MD degree from Wayne State University School of Medicine in 1950. A general surgeon, Doctor Bremer was affiliated with Cottage, Deaconess and Harper hospitals. He served in the US Navy air corps during World War II.

Elmer H. Carroll, MD
Birmingham

Elmer H. Carroll, MD, Birmingham, died June 23 at the age of 88. Doctor Carroll was a 1921 graduate of the Detroit College of Medicine. He was a general practitioner, and was affiliated with Providence Hospital of Southfield for more than 51 years. Doctor Carroll was a member of Phi Beta Pi medical fraternity.

F. Bruce Fralick, MD
Pinckney

F. Bruce Fralick, MD, Pinckney, died July 6. He was 80. Doctor Fralick, chairman of the U-M Medical School's department of ophthalmology for 35 years, earned his MD degree from that school in 1927. He was both a teacher and a surgeon, and was responsible for many clinical innovations in cataract surgery. A surgical suite at the U-M Kellogg Eye Center bears his name.

John P. Galvin, MD
Harper Woods

John P. Galvin, MD, Harper Woods psychiatrist, died July 12. He was 51. Doctor Galvin practiced with East Pointe Associates. He earned his medical degree from the University of Michigan in 1962, and was affiliated with Harper, St. John, Cottage, Bon Secours and South Macomb hospitals. He served as a captain in the US Air Force.

Verne L. Hoshal, MD
Durand

Verne L. Hoshal, MD, Durand, died April 28. He was 73. Doctor Hoshal was former president of Shiawassee County Medical Society. He was a 1937 graduate of the University of Iowa Medical School, and was affiliated with Durand Community Hospital, and Hurley and St. Joseph hospitals of Flint.

John P. Marsh, MD
Grand Rapids

John P. Marsh, MD, Grand Rapids, died June 4 at the age of 90. Doctor Marsh maintained a general practice for 47 years. He was a graduate of the McGill University School of Medicine of Montreal, and served with the Royal Canadian Engineers in France and Belgium during World War I. Doctor Marsh was affiliated with Butterworth Hospital.

Harold V. Morley, MD
Alanson

Harold V. Morley, MD, Alanson, died May 30 at the age of 73. He was a former chief of staff at Oakwood Hospital in Dearborn, and had been an associate professor at Wayne State University prior to his retirement five years ago. Doctor Morley was a 1936 graduate of Case Western Reserve in Cleveland, and was affiliated with Mt. Carmel Mercy, Harper, Grace and Detroit Receiving hospitals.

Fernando N. Salazar, MD
Trenton

Fernando N. Salazar, MD, Trenton, died July 2 at the age of 55. Doctor Salazar, a dermatologist, earned his medical degree at the University of Bologna, Italy. He came to the United States to continue his training at Wayne State University School of Medicine.

Loren W. Shaffer, MD
Boynton Beach, Florida

Loren W. Shaffer, MD, formerly of Grosse Pointe, died June 3. He was 90. Doctor Shaffer earned his MD degree at the University of Michigan Medical School in 1917. He did his residency at Mayo Clinic, and was a consultant for the US Public Health Service. He had been a professor of dermatology at both U-M and Wayne State universities prior to his 1960 retirement.

Ronald W. Spalding, MD
Sonora, California

Ronald W. Spalding, MD, formerly of Gobles, died January 16. He was 78. Doctor Spalding was former president and treasurer of Van Buren County Medical Society. He was a graduate of the College of Medical Evangelists, and was affiliated with Allegan General Hospital. He was a general practitioner.

George H. Zinn, MD
Grosse Pointe Woods

George H. Zinn, MD, Grosse Pointe Woods, died June 1. He was 94. Doctor Zinn was a Detroit surgeon for more than 50 years. He was senior staff physician at Harper Hospital before his retirement in 1981, and also had been affiliated with Doctors, Crittenton, and Northville hospitals. He was a pilot during WWI.

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PRESIDENT'S PAGE/*Continued*

My contact with the current generation of medical students and residents leads me to believe they are bright, sensitive and caring individuals. If they suffered from a "pre-med syndrome," perhaps it is in response to the medical school system and its requirement for knowledge of scientific facts rather than a broad, liberal education. I think that a re-evaluation by medical schools of their admission requirements, with greater emphasis on humanities, might benefit the profession in years to come.

Mr. Roboto

Our profession is undergoing an informational explosion. Scientific and technical information is increasing at a rate of 13 percent per year or doubling every 5.5 years. It is estimated that by 1985 scientific information will be increasing at a rate of 40 percent per year or doubling every 20 months. This puts a great burden on the medical schools as well as individual physicians. In addition, there is an increase in social demands on the medical school curriculum. This makes it imperative that individuals entering medicine obtain a broad education at the undergraduate level.

Physicians have a difficult time understanding why our profession is losing favor with the general population. The last decade has seen a marked increase in the life expectancy of all age groups. We have seen a significant increase in the medical technology available to the general public, and a higher quality of medicine for a larger segment of the population than ever before. Despite these advances, the profession is viewed less favorably than in past years.

Our profession's problem may be its inability to apply our high technology in a high touch manner. We may have created a generation of "Mr. Robotos;" individuals who are highly trained in scientific fact and technology but lacking understanding of human behavior. A move by the medical schools to greater emphasis on the humanities as an admission requirement may be the first step to return the profession to the position of high esteem it once enjoyed.

CHILD PSYCHOLOGIST
WALK IN

PRESIDENT'S PAGE

Medical humanities education could help restore esteem

By Donald K. Crandall
MSMS president

One of the benefits of being MSMS president is that you are asked back to places that have long since forgotten about you. One such occasion was when I was asked back to my undergraduate alma mater, Albion College, to give the "Gerald R. Ford Institute for Public Service" lecture. The address was entitled "Liberal Arts Education and the Professions." This gave me an opportunity to reflect on medical education and its future directions. I would like to share some of my thoughts with you.

It is important to understand the origin of our current medical education systems. The first medical school in the United States was established in 1765. Although there were many good medical schools in the early 1800s, by the 1850s there was a surplus of proprietary schools offering MD degrees with six months of schooling and no practical demonstration or clinical teaching. In 1847 the AMA was formed primarily because of concern over the quality of medical education. In 1848 the AMA developed minimum standards for medical schools, and in 1905 advanced the five year medical school and ideal standards for preliminary education. At that time there were 166 medical schools in existence in the U.S. 1909 brought the Flexner Report, which evaluated medical schools against a model medical curriculum. By 1922 only 81 medical schools were still in operation, the others unable to meet the developed standards. The AMA and its related organizations also have developed standards for post graduate studies, hospitals, medical school departments, national boards, CME, and other related educational activities.

Pre-med syndrome

In undergraduate schools recently there has been a generally recognized malady called the "pre-med syndrome." This is not limited to medicine but is also seen in students preparing to study law as well as other professions. The "pre-med syndrome" is sometimes described as a set of undesirable attributes, widely perceived to characterize some, but not all, students whose goal is to gain admission to medical school. It implies, perhaps unfairly, that the student may be overachieving, excessively competitive, overspecialized, and narrow in thought and feeling. In its simplest form, the "pre-med syndrome" may be characterized as a compulsion to gather scientific facts rather than to acquire a broad liberal education.

Physicians, as well as other professionals, are likely to have an important role in society in addition to serving the public professionally. They should, therefore, have an understanding of the complex factors that have influenced social, political, and economic changes in the past, in order that they are prepared to contribute constructively to changes of society. Understanding of literature, art, history and philosophy are necessary to have effective communication as well as an understanding of the influence of social and economic problems we face. An awareness of contemporary society, as well as of the arts and humanities, might temper the rigidity of a strictly technological career and provide further opportunity for diversion from the stresses of a demanding career. The communication skills would also make one a better physician, able to apply our vast terminology in a high-touch, humanitarian way.

It is for these reasons that the AMA's Council on Medical Education developed its "Future Directions for Medical Education." One of its recommendations is that "schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable."

Continued on page 623

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References: **1.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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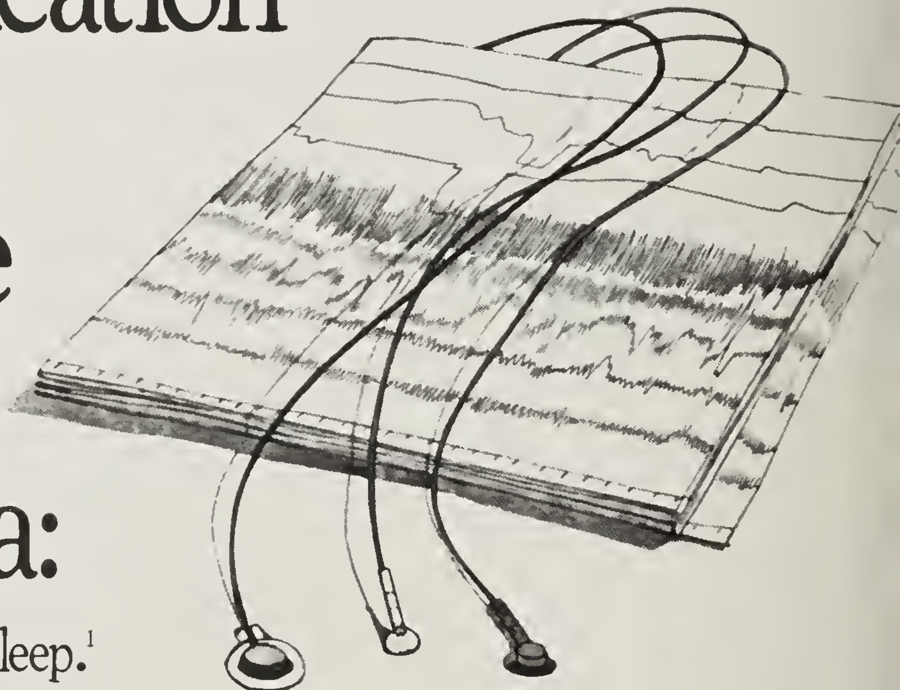

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- More total sleep time on the first 3 nights of therapy.[1]
- More total sleep time on nights 12 to 14 of therapy.[1]
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Vol. 82, No. 48 October 20, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

MSMS EAGER
TO GAIN NEW
STUDENT MEMBERS

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Welcome Students!

Michigan medical students have the best ever opportunity now to become members of county, state and national medical societies. And with this issue of Medigram, MSMS is reaching out to every medical student across the state to offer memberships at a special low rate.

Due to the action of the 1983 MSMS House of Delegates, students at Wayne State University, University of Michigan and Michigan State University may join the Wayne, Washtenaw and Ingham county medical societies, respectively, and MSMS dues-free for the first year. Students may then join the AMA for $20 and obtain a subscription to the Journal of the American Medical Association.

Medical students joining MSMS will automatically become members of the MSMS Student Section, which annually elects three delegates to the MSMS House of Delegates meeting representing each of the medical schools. Student members are placed on the mailing list for the MSMS journal and this newsletter, qualify for a group-rate insurance policies and are allied with organized medicine, one of the strongest voices for the physician in training, as well as the practicing physician.

This Medigram follows MSMS participation at orientation meetings for all three medical schools hosted during the past month by members of the MSMS Medical Student Section. Accompanying this Medigram is an application form for students interested in becoming MSMS members. The forms should be completed and returned to the appropriate county medical society. Details are available from Richard Campau at MSMS (517/337-1351).

HOUSE TASK FORCE
TAKES MSMS LEAD
ON MD MANPOWER

A state-level subcommittee paralleled MSMS thought when it adopted a final report Oct. 11 on the topic of health manpower. The report agrees with MSMS that there is an increasing supply of physicians, but that it is impossible to talk about a future surplus because of the difficulty of quantifying future needs for physicians. The report calls for further study of major factors currently in flux which make it difficult to determine the future need for MDs. They include FMG immigration patterns, competition between MDs, changes in the reimbursement system, changes in the composition of the physician pool, the effects of any recession, the aging of the population and the advances in medical science. A task force is to adopt a larger report on health manpower and the cost of medical education by January, and to pass it on to its parent House Appropriations Subcommittee on Higher Education to help guide its decisions. MSMS, which played a major role in writing the report, is represented on the task force by Warren F. Tryloff, MSMS director.

SENATE JUDICIARY SEEKING ANSWERS TO MALPRACTICE PROBLEM

With the State Bar and MSMS at an impasse on needed changes in the state's medical malpractice legislation, the Sen. Judiciary Committee has formed a new subcommittee to do its own study. The subcommittee is led by Sen. Basil Brown (D-Detroit), who also chairs the Judiciary Committee where malpractice system reform legislation (SB 224) is lodged. Members are Sen. Patrick McCollough (D-Dearborn) and Dan L. DeGrow (R-Troy).

MEMBERS MUST HAVE STATE RESIDENCY FOR MSMS INSURANCE

To inquiries as to what happens to an MSMS member's group health insurance coverage if he or she spends a substantial portion of the year out of state, the MSMS Department of Member Services and Operations replies: Physicians must live in Michigan six months of the year and maintain a Michigan residency to be carried on the MSMS group plan. If physicians do not meet these requirements, they will be canceled from the MSMS group policy and transferred to the BCBS group in the state in which they live. Physicians should keep their insurance company up to date on changes of address.

CAPSULES

The MSMS-founded Physicians Review Organization of Michigan (PROM) received a loan Oct. 12 from the MSMS Board of Directors to enable the organization to begin bidding for the PRO contract in Michigan. PROM also approved two contracts for review of the appropriateness and quality of care of cases brought to the organization by MESSA and Blue Cross Blue Shield of Michigan insurance companies. . . . "If You and Your Doctor Have a Problem" is the title of a helpful MSMS brochure available for MSMS members' patients. The brochure describes procedures to help patients and physicians work through difficulties. Copies are for sale for $5 for 50 and $8 for 100. Contact Vada L. Davis at MSMS headquarters. . . . REMINDER: MSMS delegates and alternates may mark their calendars now for the 1984 MSMS House of Delegates meeting May 4-6 at the Grand Plaza Hotel, Grand Rapids. . . . Dates are set for the 1984 Michigan Doctors Medical Seminars and ski trips to Colorado. The trips are set Feb. 18-25 to Vail and March 23-30 to Snowmass. Details are available from Richard Campau at MSMS headquarters.

MEDIGRAM

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120 West Saginaw Street
East Lansing, Michigan 48823

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Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

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MAILGRAM ASKS MSMS MEMBERS ACTION ON MEDICARE PROPOSAL

The MSMS Department of Health Care Regulation and Delivery issued a mailgram Oct. 21 asking MSMS Physician Legislative Network members to contact their congressmen immediately. The subject was imminent action by U.S. House Ways and Means Committee Chairman Dan Rostenkowski to freeze physicians' Medicare fees in the inpatient setting for six months, and to mandate assignment for physicians' services to hospital inpatients. Rostenkowsi's Medicare law amendments would be enforced by requiring hospitals to only allow physicians admitting privileges on 100 percent assignment, and by assessing criminal penalties against physicians for non-compliance. Rep. Rostenkowski planned his moves following Ways and Means Committee rejection of a similar proposal.

MSMS CONTINUES SUPPORT FOR SEAT BELT USE

MSMS continues to work with the Michigan Coalition for Safety Belt Use to promote mandatory seat belt use legislation. The strategy is to promote the good health and cost containment benefits of seat belt use while HB 4203 awaits a December vote. Bill sponsor Rep. David Hollister (D-Lansing) has delayed calling for the vote until Dec. 6, when recall elections against Sen. David Serotkin (D-Mt. Clemens) and Phillip Mastin (D-Pontiac) will be over. "Because of the recall cloud hanging over the legislature, a lot of lawmakers are angry and testy right now," reports Rep. Hollister in the Coalition newsletter. "We don't want to make people any madder or uptight. We can wait awhile." The proposed bill's language, pros and cons, and statements from Coalition Chairman Robert D. Burton, MD, Grand Rapids, appear in the October issue of *Michigan Medicine*.

MAURICE CHAPIN, MD TO RECEIVE MSMS AWARD

Maurice Chapin, MD, Millington family physician, has been selected to receive the 1983 MSMS Plessner Award as the physician who best exemplifies the practice and ethics of a rural country practitioner. Doctor Chapin will receive the award at the Nov. 23 meeting of the MSMS board in East Lansing. Doctor Chapin was selected by the board in recognition of his years of community, church and school involvement, and for his devotion to the practice and the ideals of ethical medical practice. The award was established by the late Frederick K. M. Plessner in honor of his grandfather, Michael Carl Theodore Plessner, MD, a Saginaw physician in the mid-1800s.

INSIDE THIS ISSUE

A second opportunity for Michigan physicians to register for a two-day MSMS/E. F. Hutton retirement workshop in Traverse City comes to you along with this issue of *Medigram*. The registration form for the Nov. 30-Dec. 1 workshop appears on page 3.

Inside! What you can do about new medical practice realities

BCBSM CHANGES REIMBURSEMENT SYSTEM

MSMS alerts members to watch for coming issues of the Blue Cross Blue Shield of Michigan "Record" newsletter and for a special BCBSM mailing soon detailing changes in the BCBSM professional reimbursement system. MSMS understands BCBSM plans three modifications to the system--consideration of relative values in establishing maximum screens, narrowing the differential between screens in southeastern Michigan and the other two Michigan reimbursement areas, and adjusting screens to reflect location of service (i.e., physician's office).

PRIMARY CARE PHYSICIANS SURVEYED ON CHILD ABUSE

To learn more about physician attitudes and experiences relating to child abuse, MSMS has agreed to cooperate with the AMA in a survey. The joint effort will reach 10 percent of specialists in general practice, family practice, obstetrics/gynecology, pediatrics, internal medicine and emergency medicine. The survey, which is being mailed this week, is to provide the first perspective on physicians' attitudes about child abuse and to provide insights for future physician training.

MSMS PRESIDENT HAS BUSY SCHEDULE

Donald K. Crandall, MD, Muskegon surgeon and 1983-84 MSMS president, has kept a busy schedule of official events during the fall months. Here are some of his activities:

Sept. 13--Speaker, Kent County Medical Society
Sept. 21-23--Attended AMPAC Political Education Conference, Washington, DC
Oct. 11--Speaker, St. Clair County Medical Society
Oct. 21-23--Attended president's reception, Pennsylvania Medical Society, Pittsburgh
Oct. 27--Speaker, MSMS Public Affairs/ Leadership Conference, Lansing
Nov. 9--Speaker, American Medical Womens Association Annual Meeting, Detroit
Nov. 9--Guest, Detroit radio station WJR "Focus" show

TWO MORE HOSPITALS END PARTICIPATION WITH BCBSM

Both hospitals in Benton Harbor/St. Joseph--Mercy and Memorial, respectively--have ended participation in Blue Cross Blue Shield of Michigan reimbursement programs. The hospitals, only 10 percent of whose patients had BCBSM insurance policies, departicipated as of Sept. 1. They follow Kalamazoo's Bronson Hospital and Escanaba's St. Mary's Hospital in departicipation decisions. According to a Benton Harbor/St. Joseph hospital spokesman, the depar decision has brought about no great changes. No adverse comments have been heard from patients, he told Medigram. The reason for the departicipation, he said, is the hospitals' unhappiness with the discrepancy between what the hospital charges and what BCBSM pays on hospital bills. An analysis of the Kalamazoo experience, where things haven't gone as smoothly, will appear in the December issue of Michigan Medicine.

WHAT YOU CAN DO

to adapt to the new economic realities of your medical practice

The realities you face today include aggressive cost controls, more physicians, new financing strategies and fewer health care dollars.

Action is imperative if physicians intend to participate in the changing health care marketplace. They must become aware and active to retain significant shares of the patient care market.

MSMS has been examining a number of forces which are irrevocably altering the health care arena. Major forces among all the changes are as follows:

- A shifting emphasis in health care policy away from access to care and toward cost containment.
- A significant increase in the number of physicians and ancillary health care professionals.
- A new aggressive role of health care purchasers.

MSMS, through its Section on Medical Economics and Reimbursement, has monitored changes within the health care payment system and is prepared to help physicians deal effectively with these changes. MSMS has assessed the alterations to the Medicare system as outlined under the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Prospective Payment System (PPS) by maintaining communication and by meeting with officials in Washington.

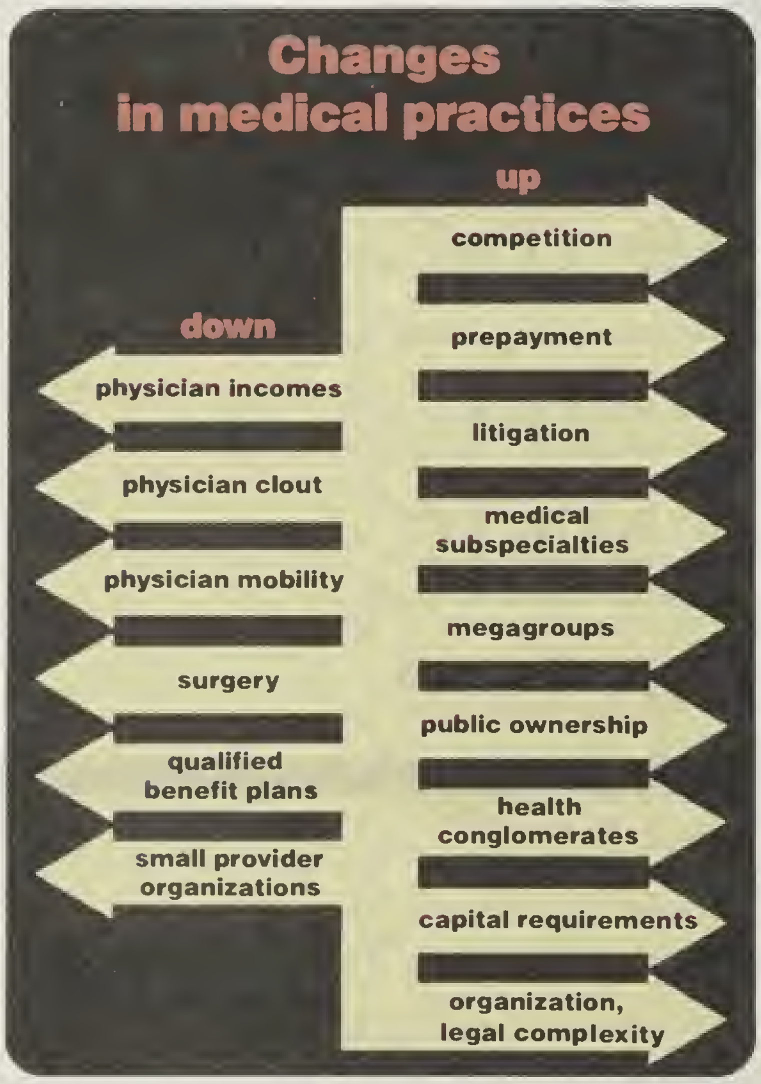
Most prominent of the changes is a reduction of funds for health care services in the inpatient setting. This has forced hospitals to develop many new financing strategies. The Section on Medical Economics and Reimbursement can facilitate physicians' understanding of and involvement in these financing systems.

Strategies hospitals are employing take many forms. Preferred provider organizations (PPOs), the lesser known joint venture concept, expansions into ambulatory care facilities and multi-level corporate ventures are among the prominent new financing strategies.

These arrangements affect directly physicians' abilities to retain patient loads, incomes and influence in quality of care issues. Thus, physicians must study all available sources of information, evaluate the health care market, and determine their best options.

The MSMS Section on Medical Economics and Reimbursement offers to individual physicians, groups of physicians, hospital medical staffs, and county medical societies expertise and knowledge regarding these hospital arrangements. The Section provides materials and/or speakers who can acquaint physicians with the information necessary to cope effectively with the changing health care marketplace.

Following is a succinct presentation of information, explanations and MSMS guidance for prudent action concerning PPOs and the joint venture concept.


Changes in medical practices
up
competition
prepayment
litigation
medical subspecialties
megagroups
public ownership
health conglomerates
capital requirements
organization, legal complexity
down
physician incomes
physician clout
physician mobility
surgery
qualified benefit plans
small provider organizations

AMA NEWS, Sept. 23, 1983

What is a preferred provider organization?

A PPO is a closed group of health care providers (physicians alone or in groups) which contracts directly with employers, insurance carriers or third party administrators to provide comprehensive medical services. PPOs may have many different forms and relationships. MSMS staff has gathered much information and attended several conferences regarding the development of PPOs both nationwide and locally. The Section on Medical Economics and Reimbursement also is aware of the current legislative climate and the status of PPO legislation in Michigan.

What is a joint venture?

A joint venture is a concept where physicians, alone or in groups, cooperate with a hospital to directly market services to health care purchasers. The actual structure of the arrangement varies depending on the relationship the individual physician or medical staff has with its institution. The Section on Medical Economics and Reimbursement is developing materials for physicians to evaluate these structures and is able to recommend legal counsel when necessary.

How will these new arrangements affect physician relationships with hospitals?

Hospitals and physicians, however organized, will increasingly compete for a fixed number of patients. In some instances an individual physician could be excluded from access to a large group of patients. Physicians may work with hospitals as a unit, marketing their services together, or form physician groups to market their services directly to hospitals. Either way they must learn to work together cooperatively. Physicians also need to be concerned with quality of care, to actively review costs and to develop protocol for medically appropriate cost containment strategies.

Reasons for change

- **physician demographics**
- **hospital economics**
- **reimbursement constraints**
- **employer attitudes**
- **prepayment growth**
- **regulation**
- **consumer attitudes**
- **aging of population**
- **anti-technology sentiment**
- **population distribution**

AMA NEWS, Sept. 23, 1983

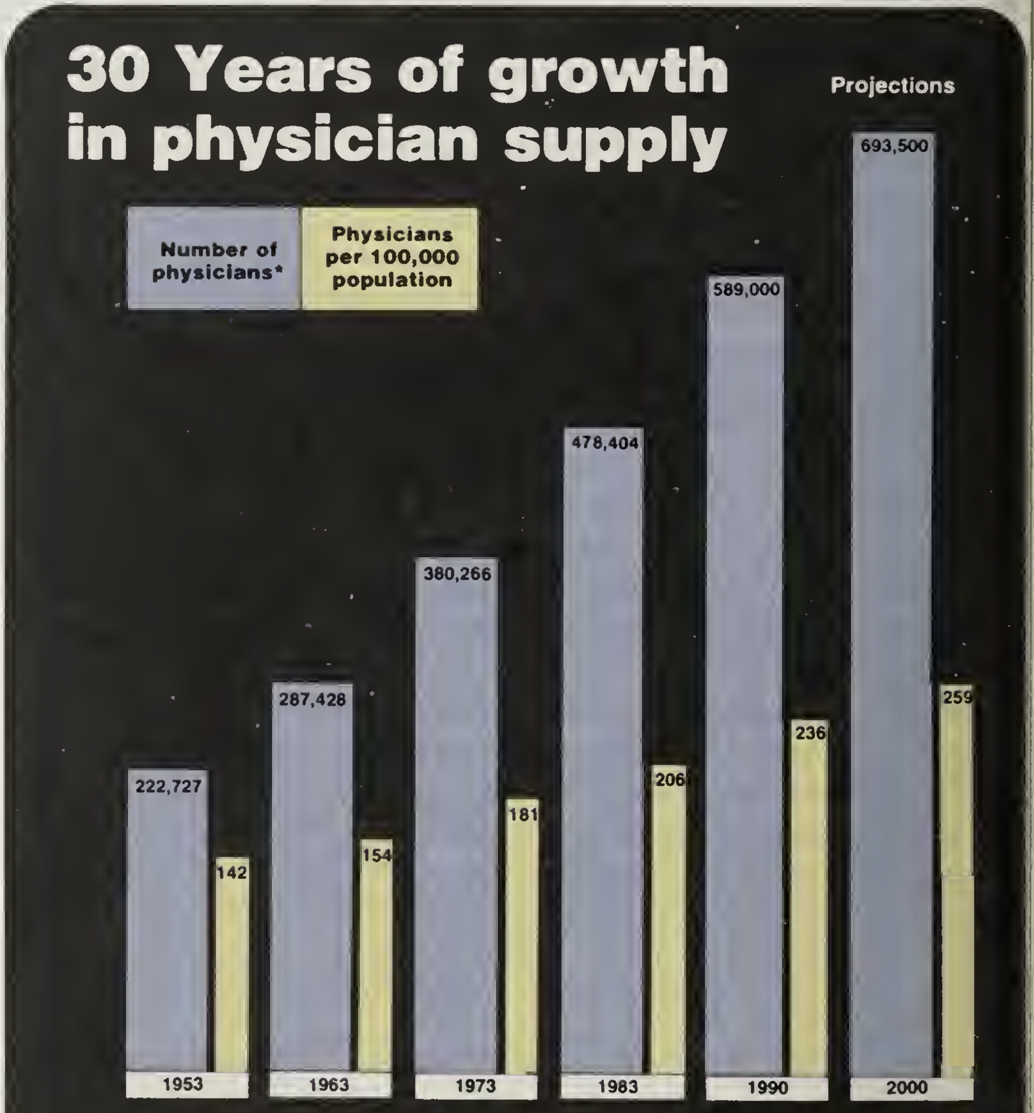
MSMS is prepared to help physicians deal effectively with these changes

What can I do?

Physicians must be flexible, able to adapt to new economic realities. By contacting the MSMS Section on Medical Economics and Reimbursement, physicians may attain additional information about these new mechanisms. Regarding the regulatory climate they should seek legal counsel. Management and consulting services should be retained in order to determine the feasibilities for these types of organizations in specific areas. MSMS can assist physicians in contacting consulting groups specializing in these new reimbursement mechanisms.

Physicians must understand that these changes have occurred and realize their significance in the health care arena. These new cooperative efforts with hospitals may supercede the traditional medical staff relationship. Successful physicians will position themselves to take advantage of the many payment systems.

In short, use your energies wisely. Learn how the new systems work and how you can most effectively practice within them.



30 Years of growth in physician supply

*Includes osteopathic physicians for all years after 1923. Sources for years prior to 1983: American Medical Association, American Osteopathic Association. Souce for 1983: Clark-O'Neill, Inc., May 1983. Source for 1990 and 2000: Bureau of Health Professions, U.S. Department of Health and Human Services (low series projections).

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“Gearing Up for Retirement”

A workshop sponsored by the MSMS Physician Service Group, Inc., and the American Medical Association

Wednesday, Nov. 30, 1983
8 a.m. - 5 p.m.
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517/627-8471

Thursday, Dec. 1, 1983
8 a.m. - 5 p.m.
Michigan Inn
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313/559-6500

Physician
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Group, Inc.

Objective

To answer all your questions on how to painlessly wind down a medical practice and gear up for a successful retirement. This workshop will detail how to close or sell a medical practice. It is strongly recommended that your spouse attend this workshop with you (at no extra charge) because retirement requires planning by both of you.

To Be Discussed

- Physician and spouse role adjustments
- Post-retirement vocational opportunities
- How to close a medical office
- Patient notification, record transfer, and retention
- Valuing a medical practice for sale
- Tax issues of selling a practice
- Post-retirement investments
- Social Security benefits
- Estate planning
- Office and family finances in event of doctor’s disability
- Wills and probate, gifts and trusts

For more details,
contact John Anthony or Caroline Rich at MSMS headquarters.

- -

Registration

Registration is limited — REGISTER NOW!
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Physician Service Group, Inc., a member service subsidiary of Michigan State Medical Society, Box 950, East Lansing, 48823, 517/337-1351.

( ) Please enroll me in the GEARING UP FOR RETIREMENT WORKSHOP on ______ 1983.

My spouse will ( ) will not ( ) attend . . . (No additional charge for spouse).

( ) I enclose $175. (Fee includes workbook and lunch for yourself and your spouse.)

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Address ____

____
City **State** **Zip**

Telephone ____

LAST CALL FOR ANNUAL SCIENTIFIC MEETING

MSMS members may register at the door for many of the 55 half-day Category 1 courses of the 1983 MSMS Annual Scientific Meeting. Some courses of the Nov. 15-17 event at the Hyatt Regency Dearborn already are filled, however, according to Sherry Fent at MSMS headquarters.

Interested physicians also may register at the door for evening events scheduled during the scientific meeting. These include MSMS/PSG Financial Planning Seminars at 8 PM Monday, Nov. 14 and Tuesday, Nov. 15. They have a $10 registration fee for physicians while spouses are admitted free. Seminar topics are "Investment Alternatives for the 80's" and "Retirement Plans: Living with TEFRA." Also scheduled Tuesday evening, Nov. 15 is the Michigan Health Council's "Wellness Workshop" at 8 PM for physicians and spouses. Details are available from Herbert Auer, Michigan Health Council, 517/337-1615.

CAPSULES

The House Ad Hoc Committee on Health Care Costs, chaired by Rep. Matthew McNeely, continues to work to shape enabling language for "prudent purchaser agreements (PPAs)," which is the term the committee is using to describe groups most commonly referred to as "preferred provider organizations (PPOs)." MSMS will keep members posted. . . . The AMA is calling on local physicians to take part in the community discussions which will be generated by the Nov. 2 and 9 public TV airings of "The Chemical People," a film on alcohol and drug abuse by minors. The film is intended to spur community-wide prevention, education and treatment efforts. . . . *The Saturday Evening Post* has announced it will no longer accept tobacco advertising effective with its March, 1984 issue. The Post now is owned by the Benjamin Franklin Society, a nonprofit corporation dedicated to disseminating medical and nutritional knowledge and to foster and support research on cancer and other diseases. . . . First-year medical school enrollments declined by 90 students across the country this year, the first drop in 17 years, according to a recent New York Times. About 32 percent of medical students who entered school in 1982-83 were women, more than three times the percentage in 1969, when enrollment of women began to increase.

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Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

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BILL AUTHORIZING PPAs ON FLOOR OF HOUSE

Legislators have begun to recognize MSMS concern that professional review be included in legislation authorizing formation of prudent purchaser agreements (PPAs). A requirement for professional review is a feature of the bill, HB 5069, authorizing PPAs (formerly called preferred provider organizations, or PPOs). The bill was reported to the floor of the House Oct. 27 by the House Insurance Committee. Prior to its approval by the committee, John A. Feemster, MD, Detroit, testified on behalf of the MSMS Committee on State Legislation and Regulations that "It is the MSMS position that all PPAs must be required to have independent outside physician peer review to assure quality of care is not sacrificed for cost containment."

HB 5069, called the Prudent Purchaser Act, sets forth the requirements and obligations of those organizations interested in establishing a PPA. It is part of a package of six bills which enable insurance companies, including Blue Cross Blue Shield of Michigan, to establish prudent purchaser agreements with hospitals, mental health facilities, dental care corporations and physicians. The bills were generated largely through discussions in the past six months of the Ad Hoc Committee on Health Care Cost Containment. The committee is chaired by Rep. Matthew McNeely, who also is chairman of the House Insurance Committee.

Main features of HB 5069 are that it requires insurers to file with the insurance commissioner written standards on which PPAs will be based, requires insurers to develop procedures to notify providers of the formation of PPAs in their area, prohibits a company from discriminating between classes of providers legally entitled to provide the same health care services, and permits providers to enter into joint agreements to sell health care service packages. The legislation also has a five-year sunset clause. MSMS observers predict a House vote by mid-November.

MICHIGAN RANKS HIGH IN MEDICAL SOCIETY MEMBERSHIPS

Michigan ranks second among the 15 largest states in proportion (79 percent) of state society members who also are AMA members. That information was shared with MSMS and county medical society staff Oct. 26 by AMA membership development account executive Terry Nugent of Chicago. Michigan is fourth among the larger states, said Mr. Nugent, in proportion (77.4 percent) of practicing MDs who belong to the state society. This fall MSMS is launching a major membership recruitment and retention program featuring letters from AMA Executive Vice President James H. Sammons, MD, and from AMA Board Chairman John J. Coury, Jr., MD, Port Huron. Special efforts will reach medical students, resident physicians and women physicians.

LEADERSHIP CONFERENCE SPEAKERS STRESS NEED FOR ACTION

Physicians are in need of strong alliances, declared Lonnie Bristow, MD, chairman, AMA Council of Medical Services, as he addressed the crowd at the 1983 MSMS Public Affairs/Leadership Conference Oct. 27 in Lansing. "The only meaningful alliance we have is the one with our patients," said Doctor Bristow. "My intuition says we must work to get closer to our patients, to demonstrate our collective trustworthiness." He warned that physicians could be corrupted and used by the impending DRG system. "If the public ever believes that physicians have become duplicitous in working with hospitals to maximize profits, the physician/patient contract will be broken and we will lose our profession. The function of medicine will go on, but the profession will end."

Doctor Bristow was one of several conference speakers who discussed the impact of government and economics upon the practice of medicine. They included Department of Social Services Director Agnes Mary Mansour, PhD, and Chrysler Employee Benefits Director Walter Maher.

Doctor Mansour asked the physicians to join her in a partnership to address the challenging dynamics of health care delivery and emphasized that health care is just one of her priorities in meeting human needs. Mr. Maher declared that he feels it is his, the UAW's and government's job to get health care deliverers to truly compete. He also said that Chrysler is running out of time in waiting for a competitive health care system to be put into place, and that it would opt for a national health insurance in its place. "Because what's the alternative?" he asked. "The status quo is simply unacceptable." Details will follow.

MSMS PAPERS DISCUSS DRGs, PPOS AND VENTURING

MSMS members have available to them two new background papers on the major economic and social changes affecting medical practice today. "What you can do to adapt to the new economic realities of your medical practice" is the title of a leaflet inserted in every member's copy of the Oct. 27 Medigram. The paper discusses physicians' options of forming PPOs or PPAs, and of joint venturing with hospitals. In addition, the MSMS Section on Medical Economics and Reimbursement has copies of a monograph on the diagnostic related group reimbursement system which originally was printed by the Minnesota Medical Association. For copies, please contact Debbie Zannoth at MSMS headquarters.

MEDIGRAM
Michigan State Medical Society
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Vol. 82, No. 50 November 3, 1983

Vol. 82, No. 51 November 10, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

LEGISLATIVE ACTION AFFECTS BILLS OF MSMS INTEREST

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As this Medigram was written, MSMS leaders were awaiting a House vote on legislation authorizing prudent purchaser agreements (PPAs) by insurance companies, including Blue Cross Blue Shield of Michigan. HB 5069, the Prudent Purchaser Act, is part of a package of six bills generated after months of discussion by the House Ad Hoc Committee on Health Care Cost Containment. The bills set the requirements and obligations of those interested in organizing a PPA, formerly called preferred provider organizations (PPOs). They are designed to make the health care delivery system more competitive. MSMS observers expect a House vote by Nov. 15; the bills then must earn Senate approval.

HB 4167, which would erase the property tax-exempt status of free-standing outpatient facilities is under study by the House Taxation Committee. On Nov. 2, MSMS members Kenneth Ray, MD, Trenton, and Richard Horsch, MD, Detroit, testified in support of the bill. They reiterated the MSMS House of Delegates' 1982 resolve to seek legislative study of the "unfair" tax-exempt status of medical care organizations competing with physicians.

NEARLY 1,000 MDs REGISTER FOR MSMS MEETING

Nearly 1,000 Michigan physicians have registered for the 1983 MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn. Other physicians may register at the door. The meeting offers a total of 18 category 1 CME credit hours; 70 educational and commercial exhibits; and dinners, receptions and business meetings of several major specialty societies. In addition, seminars on financial management will be presented by the MSMS Physician Service Group, Inc., and the Michigan Health Council will present a wellness workshop for physicians and spouses. MSMS Auxiliary members will offer physicians the opportunity to contribute to the student aid program of the Michigan Foundation for Medical and Health Education.

The Annual Scientific Meeting courses were the subject when Detroit radio station WJR interviewed Mert Scholten, MSMS communications staff, Nov. 9, on a live morning show. The interview preceded a WJR noon interview show featuring MSMS President Donald K. Crandall, MD.

MSMS TO HOST AMA HOSPITAL STAFF SECTION

Michigan representatives to the AMA Section on Hospital Medical Staffs will be guests at a breakfast business meeting planned Dec. 3 in Los Angeles. The breakfast is planned during the Dec. 1-5 meeting of the medical staff section, just prior to the to the interim meeting of the AMA House of Delegates. Purpose of the breakfast meeting is to help Michigan AMA and medical staff delegates learn more about section operations, to set objectives for the meeting and to plan strategies for election of Michigan candidates to medical staff section posts.

1984 MSMS DUES BILLINGS IN MAIL

The first 1984 dues notices are going in the mail to MSMS members Nov. 21. The mailings include a letter from the MSMS president, information about MDPAC and AMA memberships, and an offer for the installment dues option. In 1983, nine percent of MSMS members elected to pay their dues on an installment basis. If Michigan follows national trends, there will be 40 percent more physicians in the state in 1990 than now. Forty percent of physicians in 1990 will have graduated from medical school since 1978, and 50 percent of those new physicians will be female.

CAPSULES

David L. Harold, MD, Pontiac, Oakland County Medical Society legislative chairman, visited Lansing Nov. 10 as part of the MSMS Physicians Legislative Network. . . . The Nov. 20 segment of "Housecall," the MSMS mid-Michigan live phone-in TV show, will take up scoliosis. The program, aired by Channel 47 at 6:30 PM Sundays, will feature Charles O. Long, MD, Lansing, as moderator. Panelists will be Edward Sladek, MD, and Paul DeVito, MD, Lansing. . . . Interested MSMS members may buy tapes of talks delivered at the MSMS Public Affairs/Leadership Conference Oct. 27 in Lansing. Segments by Mary Agnes Mansour, PhD; John McCabe, Rep. Matthew McNeely and Lonnie Bristow, MD, are $5 each. The complete package costs $20. Order from Mert Scholten at MSMS headquarters. . . . REMINDER: The MSMS Physician Service Group, Inc., and the AMA will present two seminars, "Gearing Up for Retirement," Nov. 30 in Lansing and Dec. 1 in Southfield. Registration forms appear in the Oct. 27 Medigram. Contact John Anthony at MSMS headquarters for details. . . . The Venereal Disease Action Coalition will present a conference Nov. 30 on "AIDS--The Facts and The Issues." The conference will be held at the Engineering Society of Detroit headquarters and is supported by Blue Cross Blue Shield of Michigan and the Wayne County Medical Society. Registration fee is $30. For details, telephone 313/764-8093.

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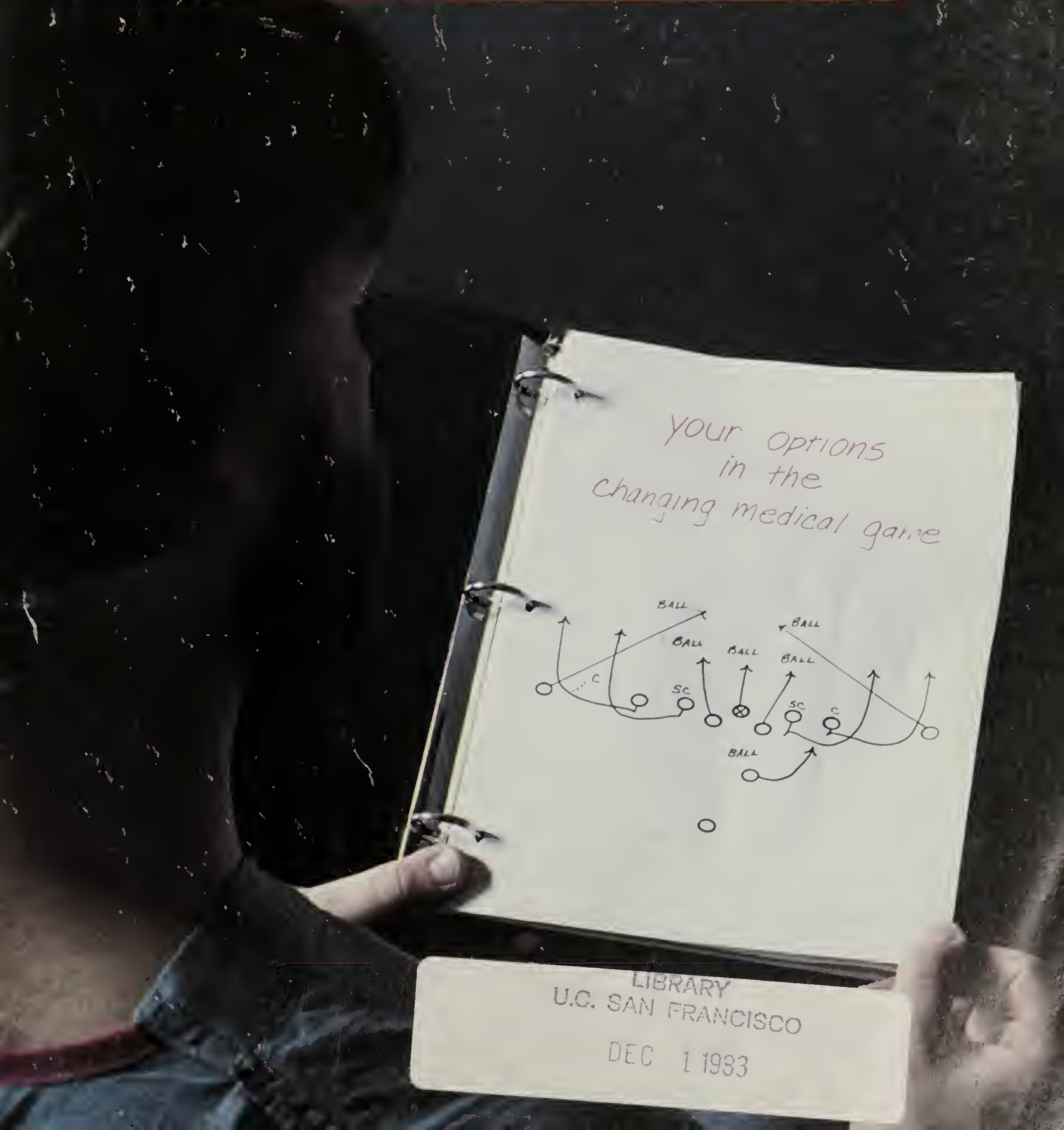
Vol. 82, No. 51 November 10, 1983

MICHIGAN MEDICINE

November 1983 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 82, Number 52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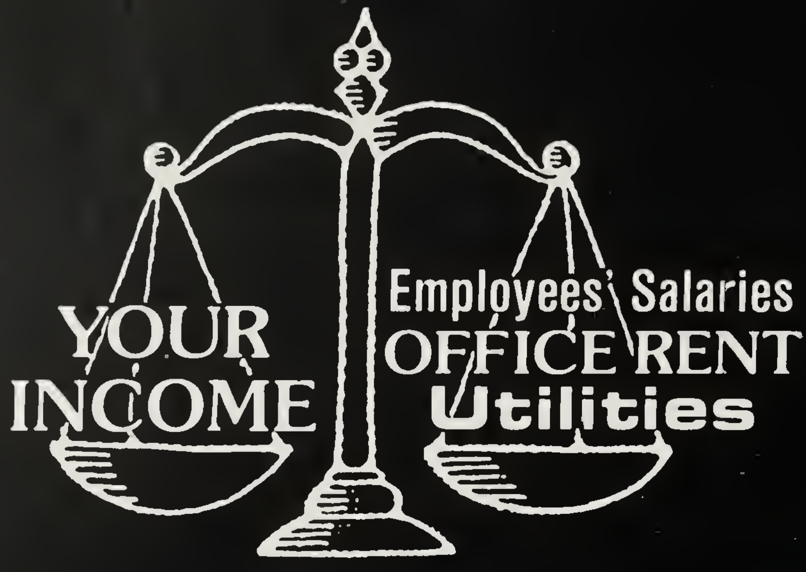

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What option does the physician take now that economic rules of the medical practice game are changing? This month's cover draws attention to two possible offensive plays outlined in our special report this month. **Photo by Kim Kauffman.**

MICHIGAN MEDICINE

November 1983, Vol. 82, No. 52

Special report

630 Medical practice is a whole new ballgame these days, as the players in Washington, business and health care institutions punt, pass and throw with increasing variety and force. Physicians need to learn new offensives and defensives, to adapt to the realities of medical economics. In this issue, MSMS provides some discussion of the option plays physicians may run, of the opposition and its strategies and of the history of the changing game. To set the tone, our illustrations are of football's option and punt plays; John A. Richards and Monte D. Jahnke

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Judith Marr

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LETTERS

Crandall 'kicks-off' new KCMS season

I'm writing on behalf of the officers and members of the Kent County Medical Society to thank MSMS President Donald K. Crandall, MD, for being our guest and speaker at the Society's September 13, 1983, meeting.

It was surely a pleasure having him with us. Too, the members needed to know what his message had to say to them. We were pleased at the attendance and consider it an exceptional 'kick-off' to a new season. We're particularly happy that he was with us when so many new young members were present to hear him.

Joseph D. Mann, MD, President
Kent County Medical Society
Grand Rapids

Headquarters' atmosphere 'professional'

On behalf of the Ingham Chapter, American Association of Medical Assistants, I would like to express our thanks to the Michigan State Medical Society for allowing us to hold our monthly meetings in the MSMS headquarters building. It is a pleasure to meet in a professional atmosphere. Thank you for your help and support.

Meridee Gerger, CMA–AC
President, Ingham Chapter AAMA
Lansing

'Buckle-up' stickers popular in the UP

Enclosed is my check for $2. Please send 200 bumper stickers (LOVE LIFE! BUCKLE UP. YOUR DOCTOR CARES). These have been a very popular handout at my office and I am pleased to see them on bumpers around town.

Richard London, MD
Hancock

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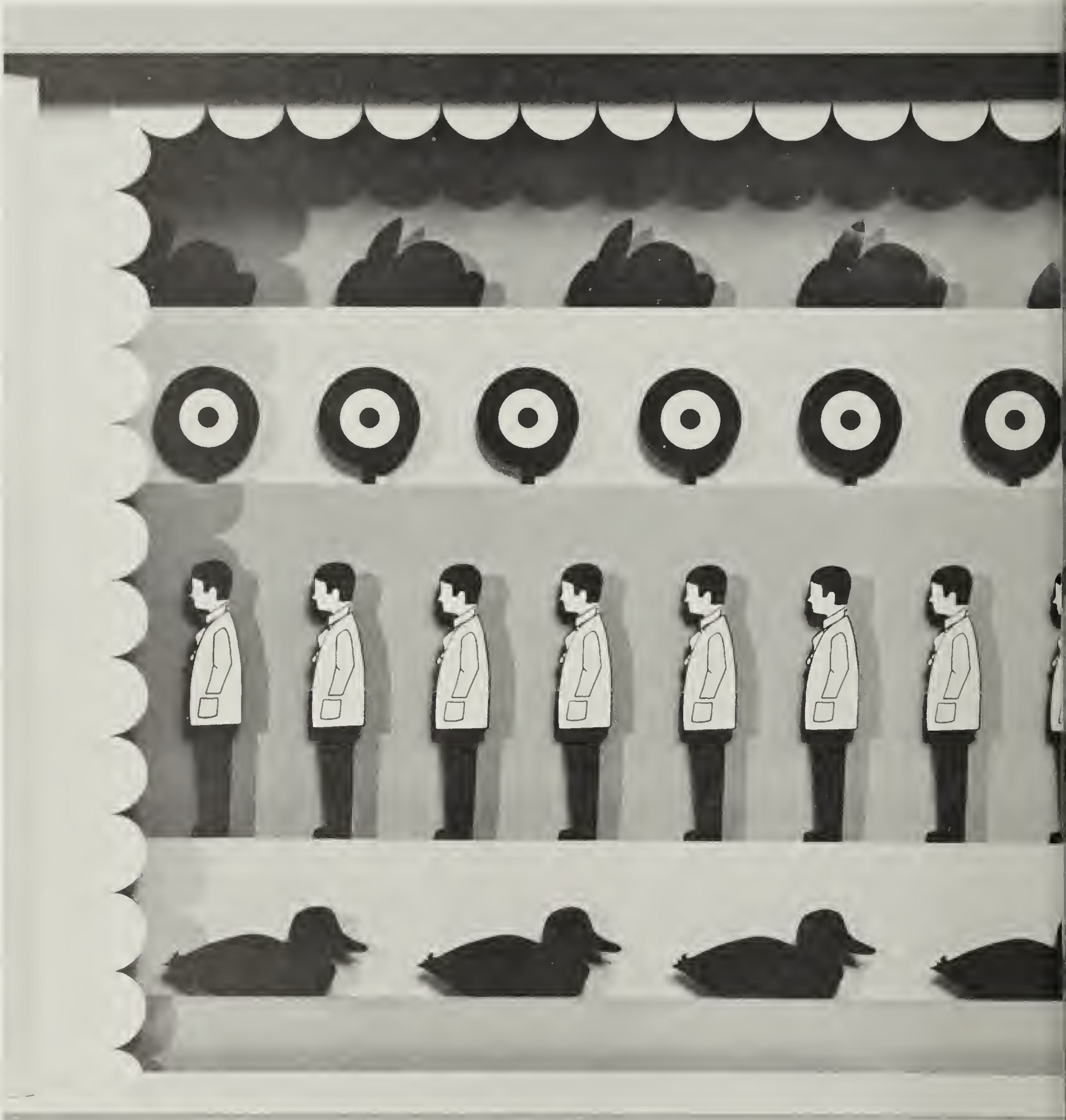

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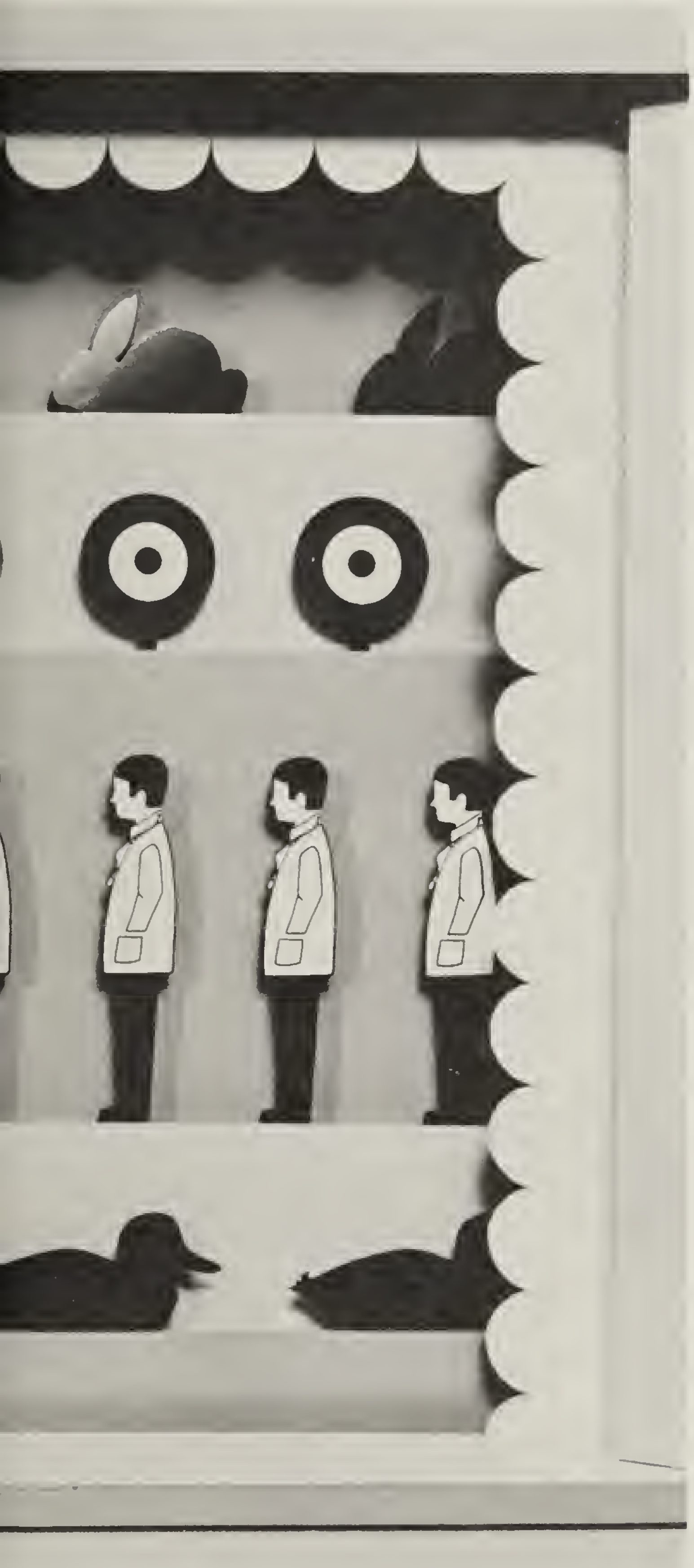

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SPECIAL REPORT

PPOs: A major option for today's physicians

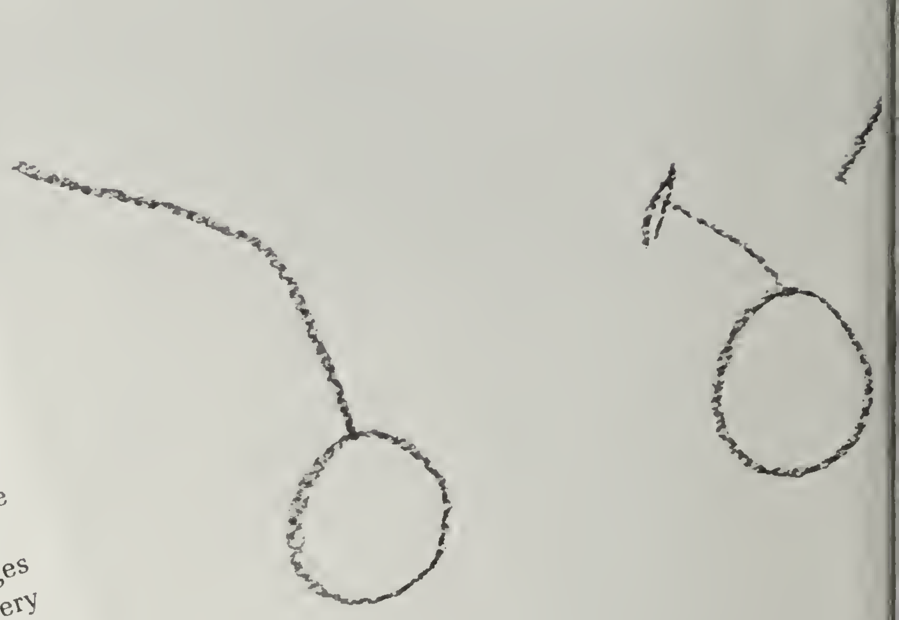
By John A. Richards
East Lansing

Several major factors are coalescing to produce significant changes in the health care delivery system in the United States. *Michigan Medicine* presents this discussion of these forces to emphasize how they will affect physicians.

Several types of financing mechanisms have evolved from the increased pressure on the system. As a result, hospitals, physicians and third parties have developed some adaptive strategies.

Although there are many changes currently occurring in the delivery system, three seem to have major effects on physicians. They are:

- A shift in both public and private policy emphasizing the cost, rather than the accessibility, of medical care.
- A significant increase in the number of physicians and ancillary health professionals.
- A new aggression in purchasers of health care regarding the type and scope of coverage for care.



Limited dollars

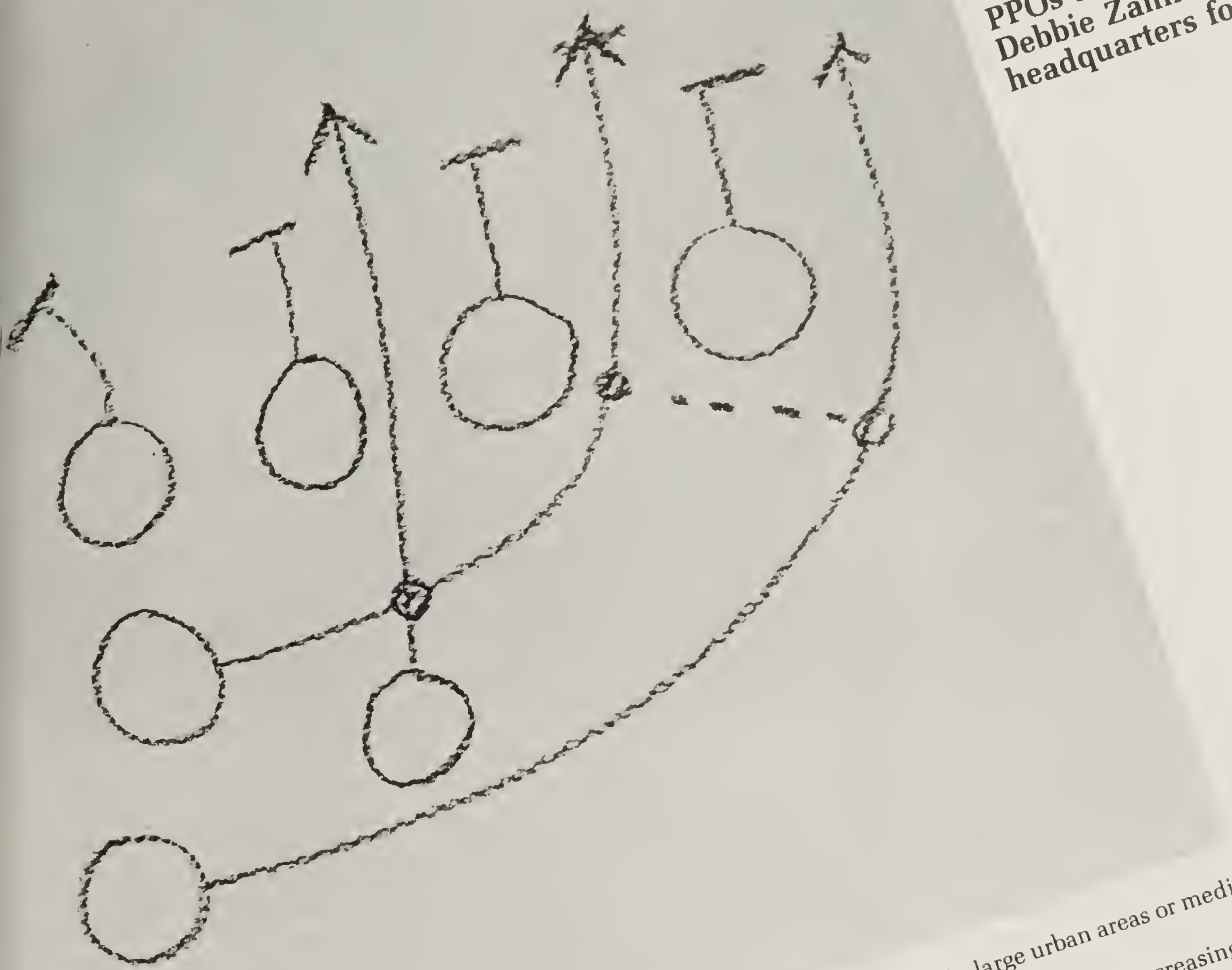
A critical factor shaping the health care delivery structure today is that growth in the sources of revenues is suddenly limited.

Since World War II the major emphasis in health policy has been on increasing access to medical care. Products of this public policy have been the Hill-Burton Act, which provided funds to build hospitals across the country, and Medicare and Medicaid. These national programs placed emphasis on making health care available to the people. In the last few years, however, public policymakers have begun seeing that unlimited access to health care results i significant cost increases.

Thus the focus now shifts to c of health care, the first of our m points above. Few groups in

Mr. Richards is chief, MSMS Section on Medical Economics and Reimbursement.

Also available!
Four-page MSMS action paper on PPOs and joint venturing. Contact Debbie Zannoth at MSMS headquarters for copies.



ntry lack access to care today be-
se of too few facilities. In addition,
ost of the population now is co-
ered by insurance programs. These
evelopments have narrowed the
growth of markets for health care delivery. Thus, there are fewer new dollars entering the system.

In the future, money available for health care will be fixed at some portion of the gross national product. This means institutions and physicians will be competing for a finite group of resources. The shares of the health care dollar currently available to the market simply will shift between institutions, physicians, long-term care facilities and other providers of medical services. Any new providers or new institutions will have to receive their income from a fixed amount of health care dollars.

The second important change is the significant increase in the number of physicians being licensed nationally. It is predicted that by 1990 there will be 40 percent more doctors in Michigan. And not only is the physician population increasing, but also the population of ancillary health professionals such as podiatrists, nurses and physicians' assistants.

The results one would expect from an increased number of physicians already are occurring in Michigan. Smaller communities now have medical specialties previously available only in large urban areas or medical centers.

Also, it is becoming increasingly difficult to get privileges on hospital staffs. Many hospitals are considering closing their staffs in order to provide adequate access to the hospital for the physicians already associated.

The third factor shaping health policy is the new role industry is taking in health care decisions. Industry feels there must be some method of reducing its total health care bill or at least of reducing the rate of increase of its health expenditures. Previous to this, companies generally have left the role of containing costs to the third party payors they selected to cover their employees. This arrangement has proved relatively inadequate.

One has to remember insurance companies primarily were designed to be financial institutions with the ability to predict the cost of medical care, collect premiums and market insurance policies. It has been only in the last few years that third party payors have been responsible also for developing programs which will contain cost increases.

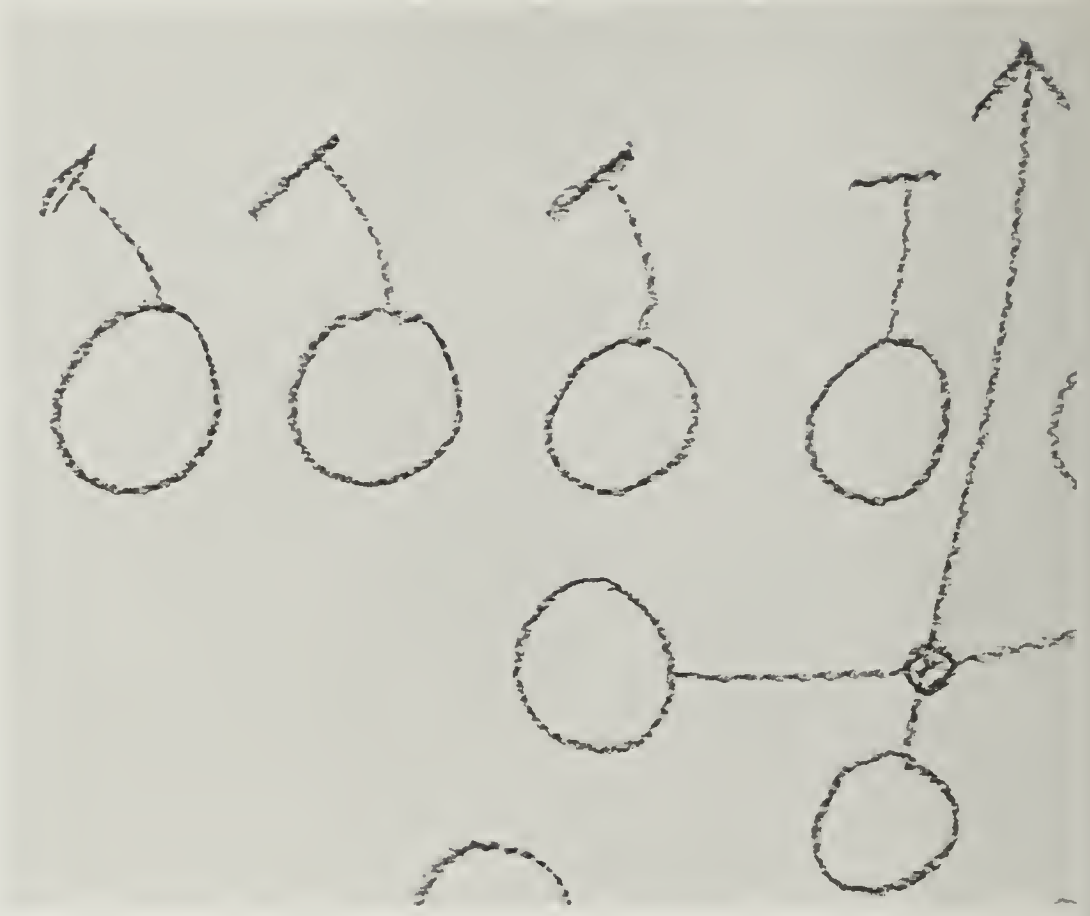
Most cost control programs instituted by third party payors could be characterized as intervening in the clinical decision-making of physicians and the corporate decision-making of hospitals. Examples are the government's certificate of need program and Blue Cross Blue Shield's second surgical opinion program.

Industry is taking the position it is not interested any more in "practicing medicine," but simply wants to have some ability to predict costs. This has resulted in programs by the purchasers of care aimed at giving their budget for health care coverage to a community organization which will guarantee employees receive a certain level of care. This organization then will be responsible for making decisions necessary to provide care within the budget.

Another example of this attitude is the recent introduction by Medicare of the diagnostic related group (DRG) type reimbursement for hospitals. Basically, DRG reimbursement is a method where hospitals are paid a fixed amount determined by the patient's diagnosis. Whether the hospital can deliver care for that diagnosis within those monetary constraints is not the concern of the Medicare agency. Medicare simply is saying this is the amount it is willing to pay for a diagnosis in this area. It is up to the institution to adjust its resources to care for the patient within the budget.

In order to survive under this reimbursement method, hospitals now are tending to make two economic moves. First, the hospital determines which diagnoses it can "make a profit on" and which diagnoses it loses money on. Then the hospital can structure itself and medical staff to admit the maximum number of profitable diagnoses.

Second, the hospital may carefully examine the behavior of physicians to see which of their ordering practices maximize the hospital's profits by DRG. The most efficient physicians will be encouraged by the hospital, while those with the most intense ordering patterns and who incur the most costs by diagnosis will be discouraged from serving the Medicare population.



Hospital physician

At this point it is necessary to understand the recent experience of hospitals' and physicians' costs. The institutional or hospital environment generally absorbs 60 percent of the health dollars available in the United States and represents the highest potential for cost savings.

Hospitals over the years have had either a static or a decreasing volume of patients and use, but their costs have increased precipitously. In economic terms this means while the number of units has decreased, the cost per unit has increased.

Historically, hospitals have been reimbursed on a cost-plus basis. Therefore, as the hospitals had economic incentive to expand and increase the intensity of services, their costs were covered. As a rule of thumb, hospital costs are 70 percent fixed and 30 percent variable. Any cost control program aimed solely at reducing the use rate of a hospital has only a minimal potential for savings. If the facility is constructed and the fixed costs already are established, any reduction in use simply increases the cost per unit of the other services.

With physicians, the cost situation is exactly the opposite. Through the third party reimbursement system in Michigan, physicians' fees (cost per unit) have been relatively fixed. In fact, under the UCR system used by the three major third parties in the state, the increase in physicians' fees has not even equaled inflation in the last five to six years. The cost problem on the physician side of the equation is the increase in use of medical services. Therefore, the cost per unit has gone down in the past few years relative to inflation, while the number of units has increased significantly.

The major organization developed in the last few years to address health care cost problems is the health maintenance organization, or capitation type plan.

Although HMOs have been successful in reducing hospital use, many times halving the number of days per thousand used by a population, their premium costs have not been reduced concurrently. The HMO reduces the number of medical units or use of medical care, but administrative or maintenance costs of this type of program increase. Also, while HMOs have successfully reduced the hospital use rate, they can do nothing about cost increases in the hospital which many times cancel the net effect of reducing use of the facility.

In order to understand what

types of systems are emerging it has to be understood an HMO is really made up of two elements. One is a closed group of physicians who have committed to having their utilization patterns scrutinized in order to successfully deliver care within a finite amount of dollars.

The second element of a prepaid plan is the actual capitation method of financing care.

PPOs form

After analyzing the experience of HMOs, a number of organizations have begun to look at the first part of the HMO structure, that is the closed group of physicians. They are forming financing mechanisms around this concept. These groups are generally called preferred provider organizations (PPOs).

Currently the preferred provider organization has no real definition other than that of closed corporation of physicians created to market services to the purchasers of care. A number of PPOs have developed in the western part of the United States and are delivering health care with direct contracts from industries.

The preferred provider movement was given additional impetus in California when the legislature authorized the Medicaid program and private insurers in the state to begin a competitive process in which physicians and institutions would have to bid against each other for a guaranteed group of patients.

In Michigan, a number of hospitals have begun to develop these types of organizations in consort with their medical staffs.

It is crucial for a potentially successful preferred provider organization to provide the full spectrum of medical services to purchasers. This means it would be difficult for a hospital to be a preferred provider without the cooperation of the medical staff. Conversely, it would be hard for a medical staff or group of physicians to create a preferred provider group absent the presence of cooperating institutions.

The areas where preferred provider organizations have a high potential for success are where there is a surplus of physicians and hospital beds and strong HMO penetration. Third parties, industries and purchasers of care in these areas feel they can be selective regarding the institutions and physicians they will "allow" access to their covered population. Generally, the purchasers of care are not interested in bargaining for the price per unit of care, but for an overall package with a group of physicians who keep utilization at a minimum and who are associated with a low cost institution.

Physicians' options

Physicians have a number of options when considering a preferred provider organization and the relationship they will have with their institution. The spectrum of relationships goes all the way from hospitals with complete control over the marketing efforts of the preferred provider organization to medical staffs which organize and act as promoters of services and have a secondary contract with a specific institution.

There is very little precedence for these types of relationships; many varieties are developing in Michigan. The most popular seems to be a cooperative arrangement where a medical staff and a hospital jointly form an organization and agree to market services.

The actual structure of a cooperative arrangement is dependent on the relationship an individual medical staff has with its institution. It is important for a group of physicians to understand the relationship in a joint venture is one of cooperation in order to successfully market their services and the institution's in an increasingly competitive environment.

In order for individual physicians to survive these changes in the health care system they must be prepared to structure their practices to take advantage of many different types of financing systems. In the future the "name of the game" for physicians will be to guarantee a patient load, as the number of providers will increase drastically while the number of patients will be constant. Physicians will have to keep an open mind about all the different forms of payment in order to provide them with the broadest base to maintain their patient load and keep a financially viable medical practice. Also, physicians will find it extremely important to understand the finances of the institutions they staff and to assist the hospital in the competitive marketplace. Physicians' decisions regarding resource allocation within their institutions will have to be based on increasing the efficiency of the hospital rather than on increasing the volume of medical services.

In conclusion, it is necessary for physicians to understand the significant changes going on within the health care delivery system. Increased numbers of providers, changing public policy and new influences from industry are coalescing to create rapid change within the financing system of health care. Physicians must be ready to position themselves to take advantage of any number of different emerging systems.

Preferred provider organizations: Characteristics and leading issues

By Monte D. Jahnke, JD
Detroit

Some basic principles and leading legal issues concerning PPOs are summarized below. These comments are broad in scope and intended to provide physicians a working overview of the topic.

What is a PPO?

No two are identical. A general definition is: An organization which delivers a broad group of health care services at discounted fees negotiated in advance using a panel of physicians who observe utilization and cost management techniques. Payments are normally fee-for-service. A PPO should place health care providers at risk financially and competitively and usually includes incentives for patients to use the PPO panel for health care. Patient choice, however, is preserved.

A PPO can be formed by payors, providers, or patient representatives. Physicians and hospitals relate to PPOs by contract. Claims are processed quickly in return for the cost effective efforts of contracting doctors.

Format. The organizational format of PPOs varies widely. Some exist as corporations, some as partnerships, some as professional corporations and some as mere joint venture arrangements.

Non-profit vs. for-profit. PPOs may operate as non-profit or for-profit entities. Often the decision on how to proceed is determined by the degree of closeness between the PPO and the hospital and by whether or not the hospital is non-profit or for-profit.

Wholly or partially "integrated"? This refers to whether the affiliated PPO physicians will work 100 percent or less than 100 percent of their time for the PPO. If a PPO is fully integrated, contracted physicians work only for it. The large majority of PPOs are partially integrated allowing physicians to maintain independent medical practices and to devote only part of their time to PPO service.

What does it mean to be "at risk"? Physicians who operate independent practices are, by definition, competitors for the delivery of health care services to patients. It is important in structuring any PPO to avoid antitrust pitfalls which might exist if a group of competitors set fees and control markets for care. Current legal perceptions conclude that by being at substantial financial and competitive risk and by organizational structuring and contracting techniques these dangers can be substantially minimized.

There are various ways of placing oneself at risk in affiliating with a PPO and several should be used simultaneously. Capital contributions and responsibility for operating costs (dollars at risk) can place each participant at risk. A program of meaningful and enforced utilization review would place each participating physician at risk competitively. Competitive fee schedules among PPO participants offering comparable medical services would definitely create the appropriate type of entrepreneurial risk for physicians.

Physician access and ongoing participation in a PPO raise other broad legal questions. An equitable basis for voluntary participation must be established, yet the PPO, by definition, must be able to enforce its utilization and cost control programs. Participating physicians over time will be cost rated and subjected to utilization review. The PPO should establish clear and fairly applied criteria for regulating physician service and preserving physician rights. These are matters of contract beyond the scope of this summary and if approached creatively should not be a disincentive to physicians.

Operational considerations

The relatively glib discussions so prominent today concerning the formation of PPOs are deceiving. The actual implementation of a PPO format can be a very complicated affair, although not unmanageable if approached carefully and diligently. It is recommended that at least the following services be contemplated by a PPO to be formed.

Management consulting services as a basis for strong, knowledgeable management. The management of a PPO requires business sophistication to implement provider contracts, market services, monitor utilization, and manage finances. Early efforts at determining feasibility, planning, and

Mr. Jahnke is a partner in the firm of Kerr, Russell and Weber, MSMS legal counsel.

development will require skillful guidance from professional consultants.

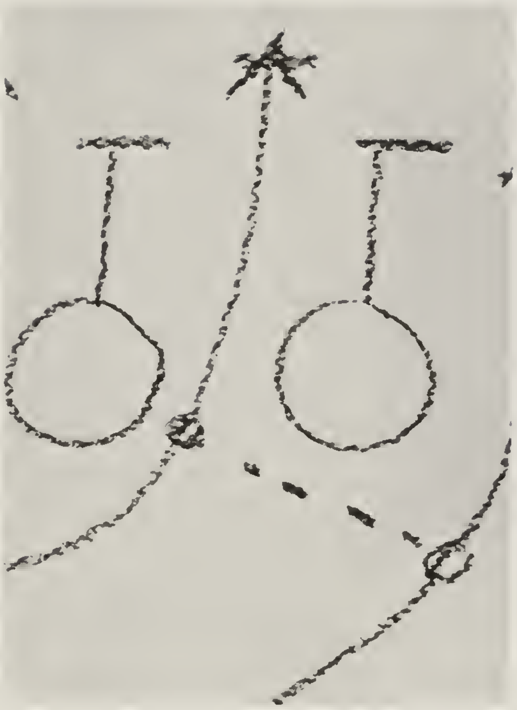
Accounting and actuarial services. By definition, a partially integrated PPO will involve portions of several existing medical practices at one time. The coordination of these activities financially will require accounting support. The projection of appropriate rates for user groups in a given area may require actuarial input, particularly for PPOs of significant size.

Legal support. Formative and operational legal services for a PPO should be as objective and independent as possible from any one or more of the individual group practices involved in a partially integrated plan. Counsel should be chosen with care and particular attention should be paid to counsel's experience with health care issues.

Financial. In addition to initial capital contributions, it may be necessary for the PPO to itself establish an ongoing relationship with a banking source or sources.

Regulatory climate

Michigan has no current statute or regulations controlling the formation and operation of preferred provider organizations. At this writing, a package of bills is under consideration. It includes enabling bills to allow hospital service and physician service corporations (i.e., Blue Cross/ Blue Shield), dental service corporations, certain insurers, and HMOs the right to contract for preferred provider services. The legislation would deem such services prudent purchaser agreements (PPAs) in Michigan. Another bill is generic in nature, broadly stating the requirements of any Michigan PPA contract. It would vest regulatory power over PPAs in the state insurance commissioner's office, mandate certain contracting standards, and preserve the rights of physician PPA panels to control panel composition.



Physicians and hospitals considering PPO/PPA projects should study the pending legislation closely with knowledgeable legal counsel. It will likely become law during this legislative session.

Hospital involvement

As much as possible, subject to the overall *caveat* that the hospital not be allowed to control the PPO and vice versa. Hospital sources are obviously important for the marketing of services to patient groups. Involvement of a hospital is vital to the overall functioning of the PPO because inpatient services will have to be provided. The hospital should be expected to negotiate competitively concerning its rates and agree to PPO protocols on hospital utilization controls.

Depending upon the hospital administration's attitude, various levels of corporate support and commitment are possible for a physician formed PPO. These could include capital contributions, start-up costs, administrative support, and marketing assistance.

Conclusions

1. PPOs provide a flexible and imaginative care delivery opportunity, combining many of the best features of fee-for-service and HMO practice. They are not risk free ventures, however.

2. PPOs allow physicians to structure and manage a practice format responsive to pressures for cost control and to the need for ongoing access to rapidly changing patient markets.

3. PPOs must be structured and managed with care. Important operational and legal issues must be addressed early on and approached with a sense of long range commitment by all concerned.

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MSMS offers these guidelines for physicians considering PPOs

Although there is currently only one preferred provider organization in operation in the State of Michigan, several major employers and third parties are actively discussing the formation of this type of financing system. With this in mind, the MSMS House of Delegates at the direction of the MSMS Council, has approved the following statement about PPOs to provide physicians with some guidance when they analyze this type of financing system.

MSMS does not have a position either favoring or opposing the actual concept of PPOs, but rather allows individual physicians to evaluate these organizations based on their own individual situations.

MSMS Statement on PPOs

Preferred Provider Organizations in Michigan should promote fee-for-service medicine, balance the marketing advantages of other financing mechanisms and encourage innovations to control health care costs.

Physicians analyze Preferred Provider Organizations based on the following guidelines:

1. The PPO plan must assess and maintain quality care by a physician-controlled peer review mechanism.
2. The PPO plan should address overall health care costs to the community including medical education, tertiary care facilities and catastrophic illness. It should not merely be a cost cutting mechanism within its select population.
3. The PPO plan must assure the physician's role as the advocate of the needs of each patient. The physician should not be placed in an adversary position by acting as an agent for the health plan.
4. PPO planning must recognize the role of the physician as the expert in selecting health care for his patients. He should select an overall cost effective treatment plan rather than provide services based solely on lowest cost.
5. The PPO plan should reinforce the concept of a continuing relationship between physician and patient.
6. Physicians must be intricately involved in the planning, organization and management of all plans involving the delivery of health care services.
7. PPO plans should provide incentives for consumers to make cost effective choices for their own health care.
8. Physicians should have access to detailed information concerning their own "practice profile."
9. Advertising for any PPO must be fair, objective and truthful. It should clearly state any limitation in services to be delivered.
10. All PPO plans should make provisions for "freedom of choice" of physician by the individual patient. This should be accomplished by including reasonable copays and deductibles for patients using physicians outside the plan.
11. Preferred provider plans should furnish a mechanism for incorporation of new physicians into their organization.

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

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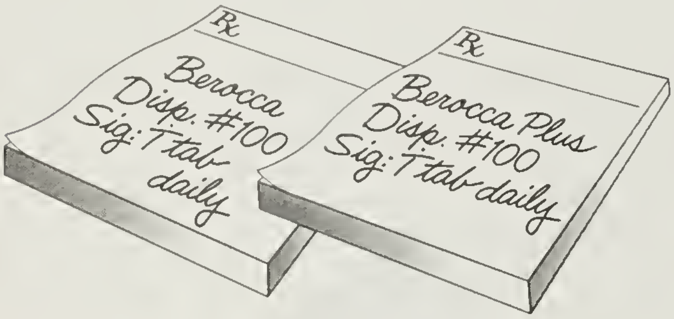

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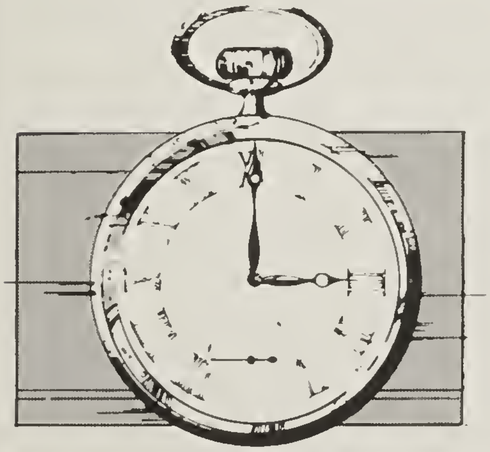

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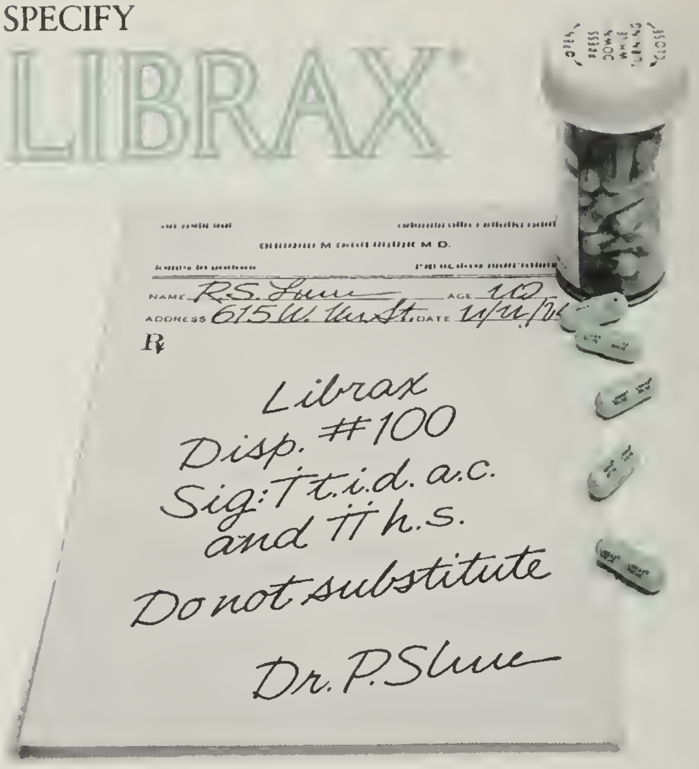

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Final classification of the less-than-effective indications requires further investigation.

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> *Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
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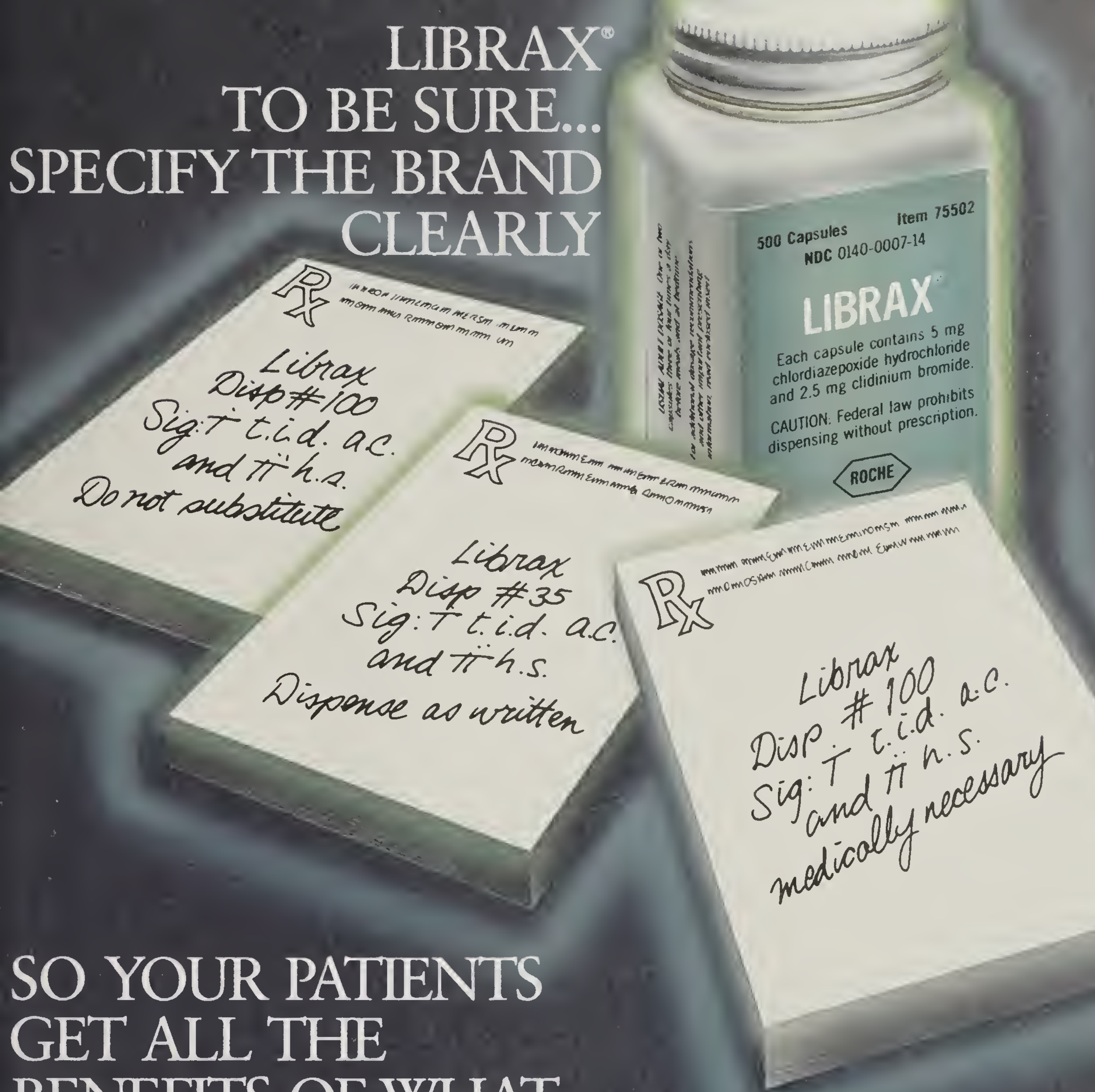
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Medicaid task force considers non-MDs as care-givers

At the Sept. 14 meeting of the MSMS Board of Directors, the MSMS Medicaid Liaison Committee reported on the drift of a special state task force toward more care of Medicaid patients by non-physicians. The purpose is to save costs. Highlights of this report to the MSMS board appeared in the Sept. 29 *Medigram.* A fuller version of the Medicaid Committee's analysis follows:

Agnes Mansour, PhD, director of the Michigan Department of Social Services, has convened a "blue ribbon" Medicaid Task Force to reassess the alternatives and policy directions of the Medicaid program. In stating her reasons for creating the task force, Doctor Mansour cited the following facts:

- Medicaid expenses are now the largest single sector of the Michigan budget — last year they accounted for over $1.4 billion, or 16 percent of all state expenditures.
- Medicaid expenditures have increased by 32 percent over the past three years, even as state revenues and state spending in other areas have declined.
- A series of executive orders, legislative directives and departmental policy changes have layered one cost containment measure upon another. All segments of the health care delivery system have shared in the resulting reimbursement reductions, with hospitals and physicians particularly affected.

Purpose

The purpose of the task force is "to review the costs, benefit structures, utilization and reimbursement policies of the Medicaid Program, and to develop recommendations for appropriate changes in program policy." The task force is chaired by Andrew D. Hunt, MD, dean emeritus of the Michigan State University College of Human Medicine, and is composed of approximately 30 representatives of consumers and recipients, business and labor, the medical and health care community and the executive and legislative branches of state government. The task force is to complete its work before the end of 1983.

Prior to the first meeting of the Medicaid Task Force, the MDSS distributed vast amounts of material describing the current Medicaid program and existing cost-containment measures. The information shows that despite all of the cost containment measures affecting recipients and providers, Medicaid continues to increase in total costs and as a proportion of the state budget.

Medicaid will increasingly have to defend its costs as it competes with other interests, particularly those of education. The last few paragraphs of the background material provided to the task force provide a sense of MDSS current philosophy, particularly as to how Medicaid relates to the overall health care delivery system. The document concludes:

"Medicaid providers have, by and large, continued to participate in Medicaid and service Medicaid patients, despite increasing levels of controls and reduced levels of reimbursement. In general, access to quality services is not a problem for a Medicaid patient who requires medical care. However, there is evidence that existing Medicaid policies, combined with changes occurring in the

Continued on page 644

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medical marketplace outside of Medicaid, are placing pressures on providers which may cause certain of them to be unable to serve Medicaid patients as they have in the past.

"Of particular importance are the several changes in the medical marketplace which make the current situation different from that which existed only a few short years ago. Notable changes include:

1. The inability of payers to afford current health care costs.
2. Changes in medical practice regarding the acceptability of providing services on an outpatient/ambulatory basis that previously were done primarily in inpatient hospital settings.
3. Changing balance of supply of medical providers relative to the supply of patients and their demand for services.
4. Changing acceptance of cost-based reimbursement, which was the keystone of Medicare and Medicaid reimbursement in the past, toward greater acceptance of fixed rate or risk-type reimbursement systems.
5. Greater recognition of differences in costs for similar services between similar providers, and a recognition of the lack of necessity to pay highest rates to achieve the necessary level of access.
6. Greater acceptance that reasonable restrictions on services may be necessary to achieve a level and scope of care that is affordable."

Agenda

In general, the emphasis seems to have shifted toward expanding services and the use of alternative providers rather than toward program/cost reductions.

The Medicaid Coverage Subcommittee, of which Allen F. Turcke, MD, Flint, is chairman, considered "designing the ideal program," which would be "budget neutral." Specific issues under consideration included the following:

1. Pharmacy — restoration of certain over-the-counter medications
2. Dental — including preventive services for the over-21 population
3. Payment for services by patients with no health insurance
4. Preventive care
5. Ambulatory nurse practitioner-operated primary health care clinics

The Alternative Delivery Systems Subcommittee has had the following agenda topics:

1. Hospice
2. Home health/personal care
3. Alternative/additional provider types
4. Out-of-hospital birthing centers
5. Facility fee for surgi-centers
6. Utilization patterns, e.g., emergency rooms

The Alternative Reimbursement Subcommittee is considering:

1. Post-graduate education in ambulatory settings
2. Fee adjustments (by procedure, setting)
3. Capitation
4. Preferred provider organizations (PPOs)
5. Case PPSP management
6. Use of HMOs

A recent joint meeting of two subcommittees of the Hospital Services Subgroup had the following issues on the agenda for discussion:

1. Preferred provider arrangements with hospitals
2. Intervention before hospitalization by clinical nurse specialists
3. Use of specialized nursing care beds for ventilator patients
4. Possibility of paying for home care outside of institutional setting
5. Increase ambulatory surgery from present 55 procedures
6. Incentives to keep patients out of institutions

One specific recommendation under consideration by this joint subcommittee is to encourage the use of nurse specialists and other "continuing care" providers as "gatekeepers" in the Medicaid program. In discussion, little attention has been given to suggestions that the use of such alternative providers must be linked to their legal authority. Instead, the recommendation's only qualifying phrase is "commensurate with their abilities."

The MSMS Board of Directors will receive regular reports on the activities of the MDSS Medicaid Task Force, its subgroups and subcommittees, particularly as specific recommendations are made for programmatic changes in the Medicaid program.

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Deductible — $100 one person
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New distribution rules for qualified retirement plans

By Curtis J. DeRoo, JD
Detroit

> **"Each participant in a corporate plan should contact his tax or retirement advisors to discuss whether an election under the transitional rule should be made."**

Every Michigan physician who formed a professional corporation during the last 10 years probably incorporated, at least partially, for retirement plan purposes. Thus, every Michigan physician who formed a corporate retirement plan (pension or profit-sharing) should be aware of the changes in the distribution rules that will go into effect for plan years beginning after 1983. Some flexibility remains, but action must be taken by January 1, to obtain the benefit of the transitional period.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) caused sweeping changes in corporate qualified (Internal Revenue Service-approved) retirement plans, such as pension and profit-sharing plans. TEFRA extended the KEOGH (self-employed) plan-required distribution rules to all qualified plans, for plan years beginning after 1983, and added several new distribution rules, as well. For pension and profit-sharing plans that operate on the calendar year basis, the new rules will be effective January 1. KEOGH plans previously were subject to some of these rules.

Old distribution rules (Pre-1984)

Under the old law, KEOGH plans and Individual Retirement Account (IRA) plans were treated differently than corporate plans:

1. KEOGH plans and IRA plans required commencement of benefits during the year the participant attained age 70½ but not before the participant attained age 59½. The only exceptions were cases of disability, when earlier payments were allowed. Payments could not extend beyond the participant's life expectancy, the joint life expectancy of the participant and his spouse, or a guaranteed period, provided the period was not longer than a participant's life expectancy or the joint life expectancy of a participant and his spouse.

2. Corporate plan distribution rules were limited only by normal retirement age and the "incidental" benefit rule, which requires that payments to beneficiaries other than the participant are incidental. This rule is satisfied if the present value of the periodic payments to the participant equals at least 50 percent of the participant's account balance at the commencement of benefits.

Example. A pension plan's settlement options include one to receive periodic installments beginning at age 65, until the participant's account balance is exhausted. Any balance remaining in the participant's account at death is payable to the designated beneficiary. A 65 year old male participant has a 15-year life expectancy. If the plan allows, such participant may elect to receive 3.5 percent of his account balance at age 65, plus earnings on his account, each year. Fifteen years x 3.5 percent = 52.5 percent. Since more than 50 percent of the present value of the payments will be payable to the participant over his life

Continued on page 648

The major changes caused by the new distribution rules can be summarized below:

1. **Required distribution at age 70½;**
2. **Possible elimination of 50 percent incidental benefit rule;**
3. **Application of five-year payout rule to beneficiaries after death of participant and spouse unless periodic payments have commenced;**
4. **Possible application of five-year payout rule to spouse if spouse is a beneficiary.**

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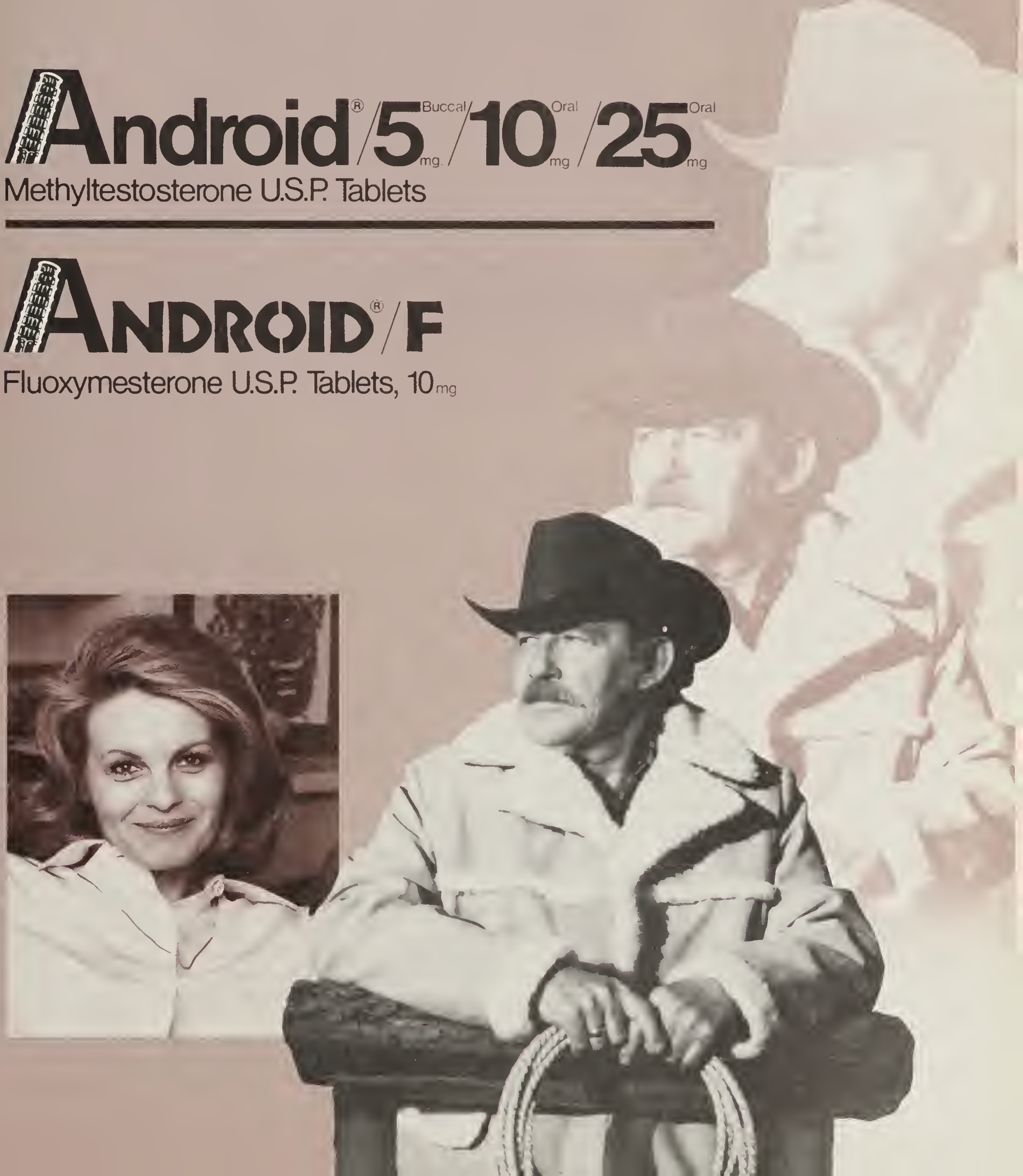

expectancy, the distribution settlement satisfies the incidental benefit test. Regardless of whether the participant lives for 15 years, the beneficiary will collect the remaining payments over the 28.5 years of this settlement option. (3.5 percent x 28.5 years = 100 percent.) The beneficiary could be the spouse or it could be any other person or series of persons.

New Distribution Rules (Post-1983)

TEFRA imposes a number of new corporate plan distribution rules which also apply to KEOGH and IRA plans.

1. Distributions must start by the end of the taxable year in which a participant attains age 70½.

2. Distributions must be under one of the following options:

(a) Lump sum;

(b) Annuity for life of participant;

(c) Annuity for joint life of participant and spouse;

(d) Periodic payment over a period not exceeding the life expectancy of the participant or the joint life expectancy of the participant and his spouse.

3. Distributions to beneficiaries must be totally paid within five years after the death of the participant or the surviving spouse, unless the distribution began prior to death and consists of the periodic payment option listed above under paragraph 2(d). In that case, the periodic payment will continue in accordance with its terms.

Although TEFRA was passed by Congress on August 19, 1982, no written regulations have yet been issued by the Internal Revenue Service to clarify the new distribution rules. Despite the lack of regulations, the new distribution rules still will go into effect for plan years beginning after 1983.

Several questionable areas remain due to the ambiguous language used in the statute, notably the application of the five-year death payout rule to the surviving spouse and the application of the 50 percent incidental benefit rule.

The unofficial position of the Detroit Internal Revenue Service office is that the five-year payout rule will not be applied to a surviving spouse, and that the 50 percent incidental benefit rule will continue to exist. Whether this becomes the official Internal Revenue Service position remains to be seen.

Example. Let's assume the circumstances of the previous example. If the 50 percent incidental benefit rule still exists, the 28.5-year settlement option still is viable. If the 50 percent incidental benefit rule no longer applies, the payout would be limited to 15 years, a 65 year old male's life expectancy, or to 22 years, the joint life expectancy of a 65-year-old male and his 65-year-old wife.

However, if the participant dies prior to receipt of the first payment, the five-year rule would accelerate the 28.5 year period, the 22-year period, or the 15-year period to a five-year payout. If the spouse is a surviving beneficiary and the five-year rule applies to the spouse, the spouse must take the proceeds within five years. If the spouse is not subject to the five-year rule, she could take the remaining payments over her life expectancy. If the spouse is also age 65, her life expectancy would be 18.2 years.

Result: The 28.5 year payout in the previous example may be reduced to five years under the new distribution rules.

This is an extreme example, but could happen easily. If a participant age 65 desires to retire, and has a 58-year-old working spouse, they may decide to wait two years until the spouse retires at age 60, prior to commencement of benefits for the husband. If the husband dies prior to commencement of benefits, the five-year rule might apply.

"It's rot all right, Senator, but it's tommy, not jungle."

Corporate Plans (Action required by January 1)

The Internal Revenue Service transition rules will allow corporate plan settlement options under the pre-TEFRA rules to continue after TEFRA becomes effective. That is provided a participant files an election with the plan administrator prior to January 1, designating a method of distribution under the plan as it existed prior to the new TEFRA rules.

The Internal Revenue Service has not issued regulations concerning this election form, so its exact format and the information it must contain is unclear. It is reasonably certain that the election will be revocable, as the Internal Revenue Service presumably will not prevent changes to a more restricted distribution option at a later date. The transitional rule only applies to corporate plans. KEOGH plans and IRA plans are not eligible for this special transitional rule.

A corporate plan participant should seriously consider filing an election with his plan administrator under the transitional rule if the participant desires:

1. To delay the commencement of benefits beyond age 70½;

2. To take advantage of the 50 percent incidental benefit rule (which may or may not be available after January 1);

3. To allow the spouse to receive payments over a period in excess of five years in the event of the participant's death. (The five-year rule may or may not apply to a spouse.)

4. To allow ultimate beneficiaries to receive payments over a period in excess of five years.

Each participant in a corporate plan should contact his tax or retirement advisors to discuss whether an election under the transitional rule should be made. If so, it should be presented to the plan administrator prior to January 1, 1984. Each plan administrator should notify the plan participants of this option in time for them to contact their tax advisors and determine whether to file an election under the transitional rules.

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WORTH SHARING

From time to time *Michigan Medicine* will reprint excerpts of well-put essays on the current medical scene. The following example was suggested to us by enthusiastic MSMS members who wished to see these comments further disseminated. Have you seen something good lately you would like to share with your colleagues? Please contact the editor, and we will work together to get the good word out.

A society inundated with ‘warriors’

By Robert H. Elsner
Los Angeles

Doctor Elsner

The following article is reprinted with permission from the September 5, 1983, *LACMA Physician*, magazine of the Los Angeles County Medical Association.

America already is the only country in the world with more lawyers than physicians. But there has really been an explosion — as if we didn't know — in the number of attorneys during the past two decades, and the total should reach one-million by the mid-1990s if the present pace continues.

Even the lawyers are starting to worry about their profession's future, as evidenced by some concerns expressed at late July's American Bar Association's national convention in Atlanta.

One million

One ABA official suggested "We are perhaps reaching a point where the numbers are becoming more than we can handle."

In 1960, the number of U.S. lawyers numbered 250,000, according to a statistical study from Barbara Curran of the American Bar Foundation. Today, she reports, that number is nearly 622,000 lawyers. "By the close of 1987, there will be 750,000 licensed lawyers," Curran said, adding that if the mortality rate and law school admissions remain constant, "we may expect that the legal profession will reach the one-million mark by the mid-1990s."

Back in 1960, one of every 632 persons in the U.S. was a lawyer. By 1970, according to Curran, the ratio was one of every 572. Now one of every 375 persons is a lawyer. Of course, the ratio varies in certain communities. For example, in Washington, DC, there is one lawyer in private practice for every 65 residents.

Concerns expressed by some delegates at the recent ABA convention centered around declining income, underemployment and even unemployment among lawyers.

Back in the 1960s, then-President Lyndon Johnson complained about the "shortage" of 50,000 physicians in America. President Johnson was speaking more from a political than a practical perspective, and today there is a serious "physician glut" or surplus in many communities, and in the nation as a whole. The number of U.S. physicians grew faster in the 1970s than in previous decades, increasing significantly more rapidly than the population as a whole.

The Graduate Medical Education National Advisory Committee (GMENAC) has predicted an *oversupply* of 70,000 physicians in 1990, and 140,000 physicians in the year 2000.

Unlike the legal profession, however, medicine has faced the problem more squarely — not only through GMENAC, but by actually reducing and leveling the number and growth of medical schools and graduates.

A surplus of physicians, however, pales when contrasted with the increasing glut of lawyers in America.

Work hungry

It would appear that the ABA and all those storefront and mushrooming law schools have not taken the problem seriously. Nor perhaps, have they heeded the warning by U.S. Chief Justice Warren Burger several years ago, about "hordes of lawyers" hungry for work, descending upon society.

It appears that the attorney glut problem has not been taken seriously by the legal profession. U.S. Chief Justice Warren Burger several years ago warned about "hordes of lawyers" hungry for work, descending upon society.

Just several weeks ago, Chief Justice Burger, speaking at the University of Notre Dame's London Law Center, said too many American lawyers do not try to resolve conflicts, but "act more like warriors."

Relating to that premise, a University of Wisconsin law professor, Ted Finman, recently warned that the increasing numbers may cause lawyers "more pressure to create a demand for their services." As if physicians, and much of American society, aren't well aware of that specter.

The big question is whether anything can or will be done to stem the tide of more and more lawyers in America — before it's too late.

Mr. Elsner is executive director of the Los Angeles County Medical Association.

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Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

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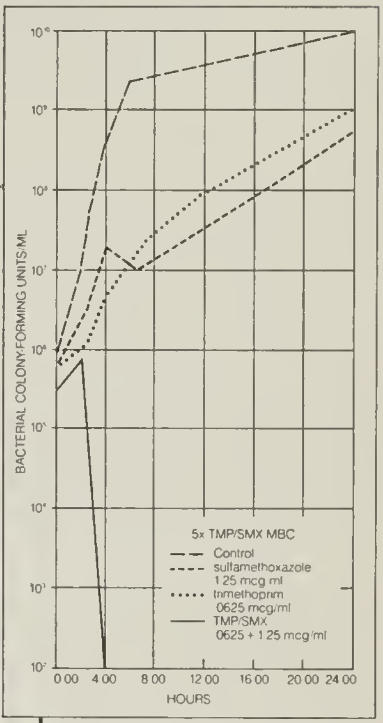
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofurantoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI**



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro.*[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro.** Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

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Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. *Pregnancy:* Teratogenic Effects: Pregnancy Category *C*. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: *Not recommended for infants less than two months of age.*

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

References:

1. Stone PH, Turi ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm: Experience in 127 patients *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina but available information is not sufficient to predict with confidence the effects of concurrent treatment especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension. Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema typically associated with arterial vasodilation and not due to left ventricular dysfunction occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis mutagenesis, impairment of fertility When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats embryotoxicity in rats mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness peripheral edema nausea weakness, headache and flushing each occurring in about 10% of patients transient hypotension in about 5% palpitation in about 2% and syncope in about 0.5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally the following have been reported muscle cramps, nervousness dyspnea nasal and chest congestion diarrhea constipation inflammation joint stiffness shakiness sleep disturbances, blurred vision, difficulties in balance dermatitis, pruritus urticaria fever sweating chills and sexual difficulties Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition more serious adverse events were observed not readily distinguishable from the natural history of the disease in these patients It remains possible however that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase CPK LDH, SGOT and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66) 300 (NDC 0069-2600-72) and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77° F (15° to 25° C) in the manufacturer's original container

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received not all patients will respond to Procardia nor will they all respond to the same degree.

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"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

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2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

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J-9043-4 July 1981

Bridging the gap between the professions

By Rhoda Powsner, MD, JD
Ann Arbor

Doctor Powsner

The following are highlights of a talk delivered Aug. 19, 1983, before the Congress of the Michigan Association of the Professions.

When we consider that this growth and prominence of the professions was never incorporated into the nineteenth century concepts which formed the basis for twentieth century expectations, it becomes easier to understand many of the problems we now face. The growth of the professions has been concurrent with vast technological advances, and as yet, neither has been graciously assimilated into our social fabric. One could speculate that the preeminence of the professions and technology is interrelated, and that the solution to the problems posed by one might presage societal comfort with the other.

Accompanying the growth of professionalism there has been a certain amount of discord between various groups exemplified in the extreme by the animosity existing between law and medicine. Some of this disharmony is capable of resolution, but some is inherent and probably a necessary part of the checks and balances of our society.

Deepest schism

The deepest schism appears to be between law and the professions which primarily utilize deductive reasoning and function in a consultative fashion. The chief difference between law and these professions, the one which seems to be the major source of conflict, results from the fact that the practice of law emphasizes adversarial relationships.

Unlike the interactions which characterize the other professions, in the adversarial system there are necessarily winners and losers. Dealing with the legal system creates problems, often unrelated to the basic dispute, for the average non-lawyer professional whose first or only contact with the adversarial process may be as a defendant in a malpractice action.

The individual who stands accused of negligence and/or battery or some other equally evil act alleged to be the result of his or her professional activities, usually has an abysmal lack of understanding of the system and an almost complete ignorance of legal reasoning.

The following graphically illustrates the dichotomy:

> *It has not been recognized generally that being sued by a patient . . . is a devastating occurrence. All of us have seen what it does to our colleagues. Even when they win the trial, they are no longer the incisive, optimistic surgeons which they were before. A court of law may be a workroom for the attorney, but it is the torture chamber for the doctor.*

The fact that the victorious defendant should be so devastated is a matter which merits consideration. Non-lawyer professionals do not really seem to grasp the fact that lawyers acting as advocates for their clients are out to win, and that they will utilize all possible avenues to accomplish this end.

You might ask what "winning" means. Are lawyers seeking to establish **THE TRUTH**, the beacon which guides scientific inquiry? Not really! In malpractice action they are striving to establish negligence on the part of the professional in order to obtain compensation. Negligence is the key; without it there will be no award. Not infrequently, issues are bent into unrecognizable shape to allow compensation for maloccurrence in an attempt to make it appear to be the result of negligence. This places the system under tension.

While lawyers understand the game, other professionals simply are not able to integrate the concepts and methods emotionally and intellectually. To them, the legal professions' credibility often becomes the issue.

In addition to the general distastefulness of the professional liability problem to the non-legal professional, the dearth of malpractice actions against lawyers tends to rigidify existing beliefs about its inherent unfairness. For whatever reason, and many believe it is the lawyer's own reluctance to pursue such actions, there does not seem to be an obvious societal expectation that the legal system can redress wrongs resulting from the negligence of lawyers.

Following the *Saikewicz* deci-

Doctor Powsner is an alternate delegate to the AMA.

sion in which the Massachusetts Supreme Judicial Court defined a legal standard for medical decisions in the care of the incompetent patient, some hospitals instituted new policies on advice of legal counsel. The events in one hospital are almost beyond description. Families actually physically barred doors to prevent the staff from resuscitating terminally-ill patients.

While I am certain in today's climate it would be considered permissible to sue a physician whose professional activities resulted in such chaos, I am equally sure that no one considered such an action against the lawyer involved in this situation. A very reasonable response to this assertion would be that the whole area dealing with legal rights in the medical treatment of the incompetent is a relatively new one, and that the advice in question is simply part of the process of evolution of legal thought.

But reasoning similarly, one could question some awards, in suits instituted several decades after the fact, to individuals who became blind as the result of retrolental fibroplasia. The suggestion that high oxygen concentrations in the incubators of premature infants might be the causative factor was in the literature at the time of the "negligent" acts; however, the practice of using lower oxygen concentrations had not been universally adopted because of concerns about other aspects of the premature infant's care.

When justified?

Or to put this issue in present day perspective, how will we know when the proper treatment for AIDS (Acquired Immune Deficiency Syndrome) has been developed, and consequently when those who might have benefitted from its use, but did not receive it, will be justified in suing for negligence?

As Derek Bok so aptly stated in his *Report to the Overseers:* "The roots of our predicament are more complex than popular impression would allow." Technological advances in medicine capture the public interest resulting in a pervasive belief that the outcome of an interaction with the medical profession will be nothing but favorable. Expectations magnified by the media too often exceed reality. The search for liver donors for dying infants is a case in point. How many people hearing the call for donor organs realize the implications of the surgery? Do they perceive when they see the picture of a smiling post-operative baby that medical care is not over; but that, in a sense, it is just beginning? The following passage from a popular novel captures the essence of this problem:

> *"All I'm saying is that splenectomy is a therapeutic failure, but not the result of misdiagnosis."*
>
> *"Who's accusing you of misdiagnosis?"*
>
> *"Well, you're accusing me of something, Miss Babcock, the way you keep coming down here and glaring at me all the time."*
>
> *"You're paranoid, Doctor Vogel." But as she thought about it she realized that she was accusing him of something — of failing to live up to the myth that modern medicine was invincible. He couldn't help it if his advance men had been overzealous in their claims.*

Specialization and isolation account for animosity between the professions. Differences in thought, differences in terminology, and even different meanings for the same word become insurmountable in the absence of communication. Jealousy over prestige and money must also be recognized as contributing to the friction, as well as battles over turf between professions whose activities overlap. Basic problems are aggravated by other factors such as activities of professional liability carriers, as well as third party payer reimbursement schemes and governmental regulations which define and distort practice patterns. Technological advances and increasing emphasis on institutions have had an impact on all professions causing a general diminution of personalized service, which has served to further alienate professions from each other as it has had an adverse effect upon society.

Some steps

There are no simple solutions to complex problems; however, having identified a number of reasons for the discord about which we are concerned, we can consider some steps for "bridging the gap."

Communication is obviously necessary for resolution of differences. In order to achieve this, the current isolation of the professions must not be allowed to continue. The professional school curriculum is the obvious place to begin through interdisciplinary courses, including a dialogue with the disciplines primarily concerned with ethics and morality.

State and national professional societies should be prepared to supplement and continue similar activities outside of the academic environment. All professions must gain an understanding of different forms of reasoning and inquiry. It is imperative that the non-legal professions develop familiarity with legal concepts and reasoning. Moreover, lawyers must acquaint themselves with, and become more tolerant of, the manner in which other professions function.

Tension would be alleviated if the professions made a serious effort to deal with unrealistic societal expectations. Scientific discoveries should be tested by scientific methods, not by the media.

The effectiveness of our adversarial system for redress of all types of professional negligence should be scrutinized. We have no conception of its actual cost, nor do we have any evidence that it is decreasing the incidence of bad practice. Its unpredictability is such that it is questionable whether it is accomplishing the espoused goals of compensating injured parties while punishing wrongdoers. Righteous expositions by those who share in the awards are not as persuasive as independent assessment. If the system is to be retained, we have to contend with the societal impact of megamillion dollar awards; if it is not fulfilling societal expectations, then we should consider separating the issues of compensation and negligence.

The concept of public service is implicit in professionalism. To carry out our obligations in this rapidly changing society we have no choice but to learn to function in a cooperative manner. Disagreement and conflicting views can be our strengths, not our weaknesses, if resolved in the interest of the public good.

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MEDICAL NEWSFRONTS

Responding to what state officials term a "desperate need," the state's three largest universities are collaborating to prepare health professionals to serve Michigan's **aging population.**

Beginning Oct. 1, federal funding of $661,092 from the Health Resources and Services Administration has been supporting development and operation of the Michigan Geriatric Education Center for three years.

The Center's goal will be to develop better ways of training physicians, nurses, pharmacists, dentists, social workers, psychologists and public health workers so that the state's growing older population can benefit from improved health care.

Advisors representing older adults of the state, government agencies, and the Legislature will work with faculty at The University of Michigan, Michigan State University, and Wayne State University to develop new education programs after surveying current programs and needs.

The Legislature's Joint Committee on Aging will name a representative to the Center advisory group, as will the Office of Services to the Aging, other relevant state departments, and the Area Agencies on Aging Association of Michigan.

Headquarters for the Center will be at the U-M Institute of Gerontology.

Detroit-area youngsters aged 5 to 14 celebrated a birthday on Sunday, Sept. 25. The birthday celebration was not their own but was of the one-year-old **Beginning Alcohol Basic Education Studies** (BABES) program at Detroit's Henry Ford Hospital.

BABES, developed by the National Council on Alcoholism, is a program designed to increase individual development by providing accurate information to children while they are still learning attitudes on health-related matters. In the BABES program, children are assisted in self-expression and exploration in order to develop valuable coping skills regarding the use and abuse of alcohol and other chemical substances.

The BABES program meets at HFH from 1 to 2:30 p.m. Sundays to coincide with AA, Alanon and Alateen meetings, and from 6 to 7:15 p.m. on Monday evenings. BABES is available free to any school or community group. For more information on the program contact Vicki Klena at 313/876-2540.

An innovative 40-minute procedure conducted at the University of Michigan Hospitals last summer cured a lifetime of **hypertension** for a freckle-faced sixth grader.

Using angiography, a procedure generally limited to examining blood vessels by X-ray, Kyung Cho, MD, delivered alcohol to wipe out kidney tissue responsible for hypertension in 11-year-old John Harvey of Burlington, Mich.

The boy's case was the second time this procedure had been tried in a child, according to Doctor Cho, a professor of radiology who has been developing intervention — or therapeutic — angiographic procedures for a decade.

Treating the disease of **cancer** is difficult enough; dealing with the emotional and mental attitude of the cancer patient and family complicates the process.

Harper Hospital in Detroit has developed a unified, multi-disciplined approach to deal with the psychological ramifications of cancer treatment.

Some examples:

Taped instructions. When a patient is first told he has cancer, he tends to 'block out' everything else that is said to him. Consequently, Harper physicians now put their initial instructions on audio cassette so the patient can review them in the privacy of their home.

Discussion groups. Weekly, 'I Can Cope' seminars are held for patients and families to provide group support in dealing with the emotional and social aspects of cancer, as well as education about nutrition, pain control, chemotherapy and sexuality.

A special weekend retreat is planned for November where patients and families will gather for a series of workshops, seminars and discussions.

Full-time medical social worker. A trained professional provides counseling and assistance for patients and families to deal with emotional needs and financial aid.

Music. Patients can select tapes of their choice to listen to during therapy and when waiting for therapy.

Artwork. Ceiling murals, children's murals and other special artwork provide a more relaxing atmosphere for patients and help relieve stress among patients and staff.

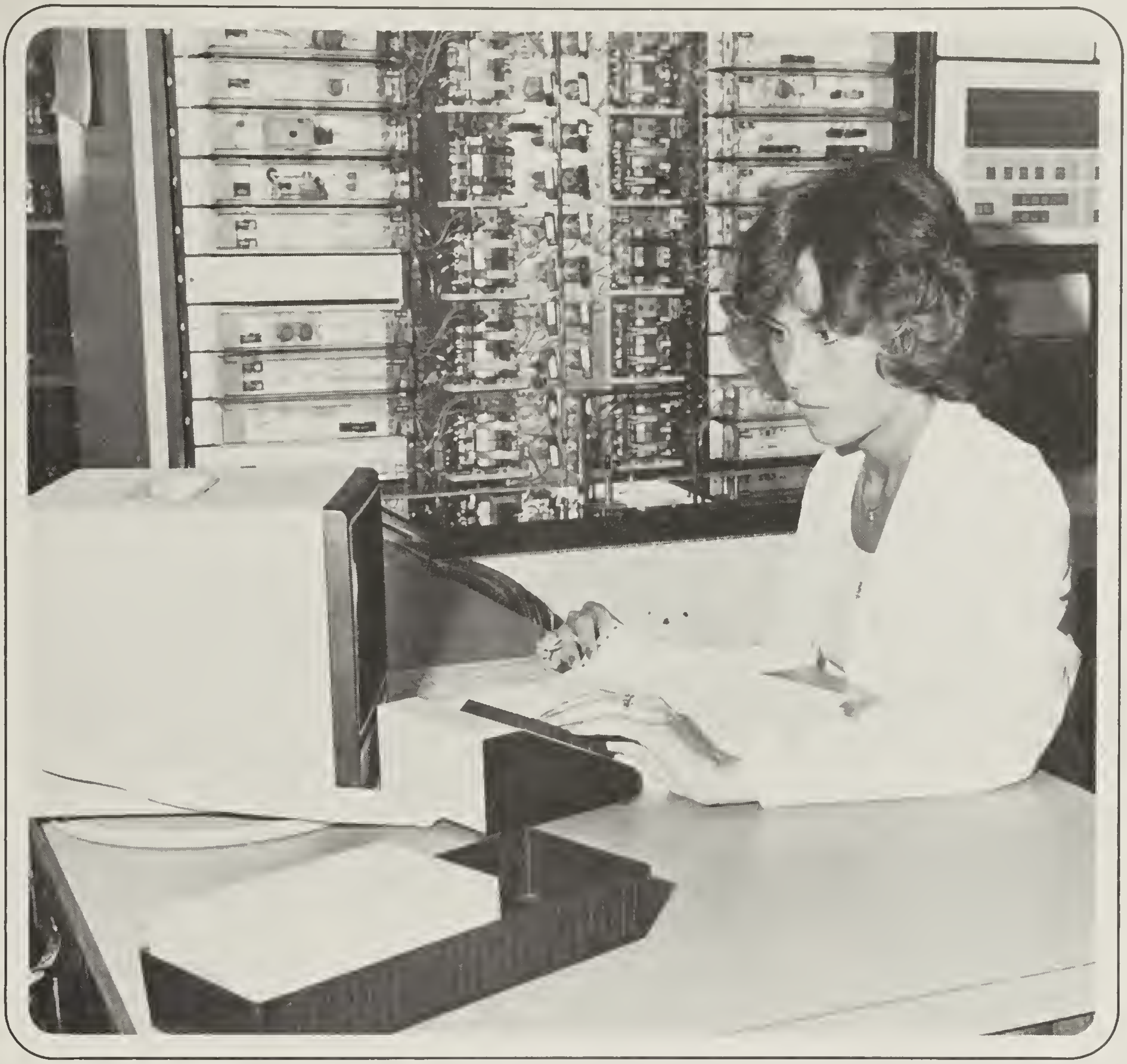
Video games. Arcade games offer fun and escapism for patients and families while waiting for therapy.

These are just a few examples of the psychological emphasis at Harper Hospital's nationally-recognized Radiation Oncology Center.

A University of Michigan research team has received a three-year $400,000 grant to look for changes between normal white blood cells and **leukemic cells,** using a technique that enables them to compare hundreds of proteins at the same time.

"We are investigating the possibility that there is something in the proteins of some cancer patients that resists chemotherapy," says Samir M. Hanash, MD, Ph.D., assistant professor of pediatrics and communicable diseases at the U-M Medical School, who is the principal researcher on the project.

With the grant from the National Cancer Institute of the National Institutes of Health (NIH), Doctor Hanash and his research team have set up a facility for a new tool — two-dimensional electrophoresis — which allows them to monitor hundreds of cell proteins simultaneously.



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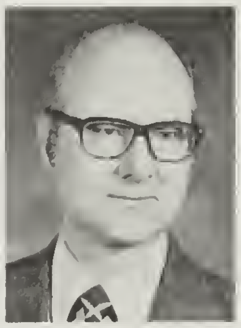
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Michigan Association of the Professions president **Vernon V. Bass, MD,** Chesaning, was recently named that organization's 1983 "Booster of the Year. . . . **Hershel Sandberg, MD,** Southfield, is one of three health professionals honored recently by the Metro Detroit Professional Medical Health Services Division for State of Israel Bonds. Each was awarded a State of Israel Maimonides Award, in recognition of their dedication to the art of healing. . . . **Roy T. Bergman, MD,** Escanaba, recently addressed a joint meeting of the American College of Sports Medicine, and the US Olympic Committee in Washington at the invitation of Vice President George Bush. . . . Surgical oncologist and microbiologist **John E. Niederhuber, MD,** Ann Arbor, was named senior associate dean of The University of Michigan Medical School by U-M Regents. Doctor Niederhuber replaces **Robert E. Reed, MD,** who has become senior vice president for medical affairs at Butterworth Hospital, Grand Rapids. . . . **Marvin Jewell, MD,** Detroit anesthesiologist, was featured in the Sept. 16 issue of *American Medical News*, published by the AMA. Doctor Jewell's medical missionary work in Thailand, Singapore and Kenya was the subject of a full-length feature in that issue. . . . **John Zettelmaier, MD,** Gobles, has written a book attacking big government called *Enuf Already: A Country Doctor Examines America.* Doctor Zettelmaier has been active in Republican politics for many years, and is a registered lobbyist. . . . **Martin C. Robson, MD,** formerly of Chicago, has been named professor and chief of the Section of Plastic and Reconstructive Surgery at WSU School of Medicine, and Chief of Plastic Surgery at Harper-Grace Hospitals. In addition he is director of the Burn Center at Detroit Receiving Hospital. He is a nationally known plastic surgeon. . . . **Vainutis K. Vaitkevicius, MD,** Pleasant Ridge, was presented with the Mercy Medallion by Mercy College of Detroit. The award recognizes his contributions to the Detroit Medical Center's cancer program. . . . **William H. Beierwaltes, MD,** Ann Arbor, received two awards recently for his work on cancer treatments. He was the first American to receive the Johann-Georg-Zimmerman Award for Cancer Research presented by the Friends of the Medical School in Hanover, West Germany. Earlier in the year, Doctor Beierwaltes became the first recipient of the Edward Rotan Visiting Professorship at the University of Texas. . . . Three physicians from Detroit Medical Center are among seven investigators who have been awarded financial support through the National Institutes of Health Biomedical Research Support Grand for 1983-84. They are: **Virginia Black, MD; Suresh Enjeti, MD;** and **Marc Levinson, MD. . . . Edward V. Famiglietti, Jr., MD,** has received a grant through the WSU Neuroscience Small Grant Fund to support his study of visual responses. . . . **Alan E. Beer, MD,** Ann Arbor, was named Bates Professor of Diseases of Women and Children by U-M Regents. His appointment to this endowed professorship recognizes Doctor Beer's outstanding reputation in obstetrics/gynecology. . . . **Miriam Shamer Daly, MD,** Albion, was featured in the Summer, 1983 issue of *The Goucher Quarterly*, the alumni magazine published by Goucher College in Maryland. Doctor Daly was quoted extensively on balancing a professional career and a family. . . . **Ramon Berguer, MD, PhD,** West Bloomfield, recently chaired the session of surgery at the 13th World Congress of the International Union of Angiology at the Mayo Clinic. . . . **Ray E. Helfer, MD,** East Lansing, has been named associate editor of the *American Journal of Diseases of Childhood.* He also is a reviewer for the *Journal of Pediatrics, Pediatrics,* and the *International Journal of Child Abuse and Neglect.* . . . **Charles Seifert, MD,** Battle Creek urologist, was re-elected president of the Southwest Michigan Health Systems Agency Board of Trustees for 1983-84. Also appointed to the Board was **Mark Marzolf, MD,** Battle Creek. . . . this year's employee picnic at Owosso Memorial Hospital was dedicated to **Joseph F. Sahlmark, MD,** who retired from his practice recently after 40 years of service to that community. . . . **Masroor Ali, MD,** Belleville, was awarded the US Army Reserve "Pro Patria Award" for his support of the Reserve as an employer.

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Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

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For a summary of product information, please turn the page.

Valium® (diazepam/Roche) Ⓝ Tablets
Valrelease™ (diazepam/Roche) Ⓝ slow-release Capsules
Injectable Valium® (diazepam/Roche) Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> *Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i e* , phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months)

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I.M. use: by deep injection into the muscle

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given Do not use small veins, i.e., *dorsum of hand or wrist Use extreme care to avoid intra-arterial administration or extravasation Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

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Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required

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MSMS involves MDs in child abuse treatment

By Brooker L. Masters, MD
Baldwin

Without question, one of the most serious and complex issues facing society and the moral fabric of all human relations is the ever-present and growing problem of child abuse and/or neglect.

The realization that it is a matter of worldwide occurrence — and has been a part of mankind's history from the beginning — only accentuates the desperate need for an all-out effort to find solutions or, at least, an amelioration to this unexplainable tragedy.

One startling statistic can put the problem into focus: Studies show 90 percent of the inmates in the Southern Michigan Prison at Jackson have a history of being abused or neglected as children. Little good will it do to build more and more prison capacity when the source of candidates for those cells increases at such an astounding rate!

Least involved

Social agencies have addressed themselves to this issue for a long time. Today there are hundreds of agencies, both governmental and private, and thousands of individuals — all striving to develop an intelligent and workable approach to the problem.

It is not particularly noteworthy of the medical profession that it has been the group least involved over the years. Doctors who have been called upon to treat the victims have been the last people to enter into efforts to help find a solution to this blight on our progeny. There are many reasons for this neglect. But the facts are that there is no group with a better chance to influence a potential change in this inexplicable crime picture than practicing physicians. Somehow we have got to get more involved.

The directors of MSMS have recognized this need by creating a Committee on Child Abuse/Neglect. Several meetings have been held; at each meeting the loud cry from all the agencies involved is to find a way to bring the medical profession into the process.

National meeting

The American Medical Association has recognized the need as well, and is devoting considerable energy to a national effort to coordinate and be an informational source to all the state societies. A national conference on child abuse is planned for 1984.

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Doctor Masters is chairman, MSMS Committee on Child Abuse/Neglect.

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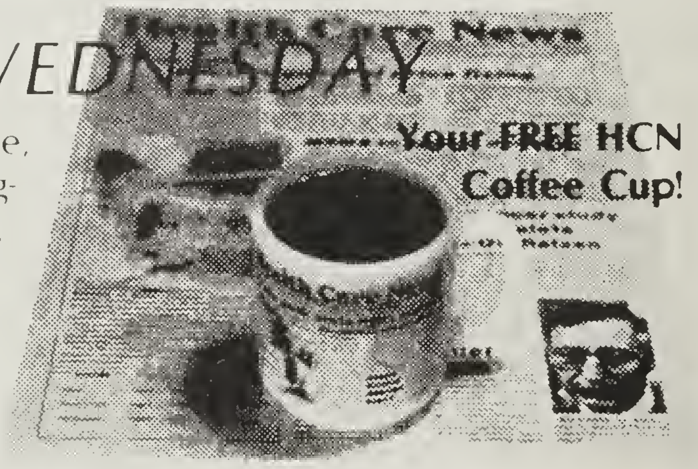

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Health Council's placement service helpful

By Janice Weitzmann
Special to *Michigan Medicine*

Two physicians who recently completed their family practice residencies in Flint are practicing today in small southwestern Michigan communities — thanks to the ongoing efforts of the Michigan Health Council Physician Placement Service.

Both David Wendling, MD, and Martin Hoffman, MD, began to use the Placement Service while in their residency training programs. They attended an MHC Physician Recruitment Conference in Lansing to find out about opportunities. There they talked with Craig Haner, administrator of the Lake View Community Hospital at Paw Paw.

Big help

This summer, Doctor Wendling set up his practice in Decatur and Doctor Hoffman in nearby Mattawan.

"The Health Council was a big help to me in finding a place to practice where I would be needed," reports Doctor Wendling. "I wanted to stay in Michigan and checked everywhere. Mr. Haner arranged for my visit to Decatur with my wife. We received a nice reception and liked the location," he continues.

Doctor Hoffman explains that he liked the location because it was rural, yet still close to larger cities and a university (Western Michigan University in Kalamazoo).

Mr. Haner is very complimentary about the year-round efforts of the MHC Physician Placement Service, a non-profit voluntary approach to helping physicians and communities.

A grant by the Michigan State Medical Society helps finance the operation of the Placement Service, along with other major grants from Blue Cross Blue Shield of Michigan, The Upjohn Company of Kalamazoo, Michigan Physicians Mutual Liability Company and the Physicians Insurance Company of Michigan. Some of the other necessary funds for salaries, travel, printing, postage and telephone are obtained from registration fees, explains Herbert A. Auer, executive vice president of MHC and a former deputy director of MSMS.

Continued on page 672

Janice Weitzmann, who researched and wrote this article for *Michigan Medicine*, is a senior in communications at Michigan State University. She recently served as a Health Council student intern.

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1. Dixon RE: *Ann Intern Med 89*(Part 2):749-753, Nov 1978. *2.* Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME: Philadelphia, Lea & Febiger, 1980, p. 1114.

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PLACEMENT SERVICE/*Continued*

Louis R. Zako, MD, Dearborn Heights, president of MHC, stresses, "A major thrust of our service is to encourage young physicians to stay in Michigan after medical school and residency training. This is done by bringing together physicians seeking a practice location and those communities in need of doctors."

"I would like to encourage MSMS members who may need an associate to use the Placement Service, the only non-profit services like this in Michigan," declares Doctor Zako.

"The demands for recruitment/placement assistance today are as great as ever. Physicians can still select the place they would like to practice, with a few exceptions. Openings exist across the state, in smaller communities such as St. Johns, Northport, Manchester, Menominee, Clinton, Hastings, Suttons Bay, West Branch and Saline," explains Mr. Auer.

100 openings

There are 126 Michigan communities today registered with MHC as needing one or more physicians. All these openings are described in the current "Roster of Michigan Opportunities for Physicians," published recently by the Michigan Health Council.

By far the largest number of opportunities is for family physicians. There are 96 family practice openings in 91 communities scattered across Michigan. The next largest numbers of openings by specialty are for 20 internal medicine specialists and for 19 obstetricians-gynecologists. Openings are listed in 27 specialized areas.

Roster descriptions provide the name of a local contact person and talk about financial incentives, cultural and educational institutions, recreational opportunities, etc. Some of the current ads include these comments, "the area provides virtually every winter and summer recreational activity imaginable" . . . "financial arrangements are negotiable to include income guarantee, office and equipment" . . . "learn more from congenial, experienced partners willing to teach."

The Roster also provides information about 26 federally-funded community health centers which are planning to employ a total of 33 primary care doctors in 1984. The Centers are located in health manpower shortage areas, so declared by the federal government. Physicians with an obligation to the National Health Service Corps (because they have accepted federal grants to help finance their medical education) must practice in shortage areas.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: November 25-29, 8th Annual Ophthalmology Basic and Clinical Review Course. Location: Hyatt Regency Hotel, Dearborn. **Sponsor:** Kresge Eye Institute of Wayne State University. **Contact:** (313) 577-1180. **Approved for:** 44 hours of Category I Credit.

Date: December 3, New Developments in the Diagnosis and Treatment of Anxiety Disorders. Location: Hotel Pontchartrain, Detroit. **Sponsor:** Brain Research Fund of Michigan, Department of Psychiatry, WSU. **Contact:** (313) 577-1180. **Approved for:** 6 hours of Category I Credit.

Date: December 3, Michigan Short Stature Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: December 5-9, Basic Principles of Manual Medicine. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** Course presents lectures, demonstrations, and practice sessions on the spine, pelvis, and extremities. **Contact:** Sandra Kilbourn, MA, Coordinator, Continuing Medical Education, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing, 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: December 7, Mediators and Vascular Injury. Location: Kresge Auditorium, Harper Hospital, Detroit. **Sponsor:** Department of Medicine, Wayne State University. **Cost:** $45. **Contact:** Richard W. Carlson, MD, PhD, Dept. of Medicine, WSU, 540 E. Canfield, Detroit 48201 (313) 577-1146. **Approved for:** 6 hours of Category I Credit.

Date: December 10, December Seminar, Michigan Society of Pathologists. Location: Rackham Auditorium, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: January 18, Otorhinolaryngology Update. Location: Henry Ford Hospital Office of CME. **Cost:** $100-practicing physicians; $50 — residents and others. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-3073. **Approved for:** 7 hours of Category I Credit.

Date: February 11, 1984, February Seminar, Michigan Society of Pathologists — "Quality Control in the Clinical Laboratory." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists in cooperation with the Great Lakes Regional Quality Control Program. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint 48503. **Approved for:** 3 hours of Category I Credit.

Date: March 17-24, 1984, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Continental Inn, Aspen, Colorado. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 30 hours of Category I Credit.

Date: April 12-15, 1984, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing, 48824. **Approved for:** 32 hours of Category I Credit.

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DEATHS

Muzaffar Ahmed, MD
Canton

Muzaffar Ahmed, MD, Canton, died August 8. He was 36. Doctor Ahmed had been head of the Anesthesiology Department at Wayne County General Hospital at the time of his death. He earned his medical degree in Pakistan in 1971, then came to the US where he did a residency at Michael Reese Hospital in Chicago. Doctor Ahmed had been affiliated with Wyandotte General Hospital, as well.

William B. Barr, MD
Perry

William B. Barr, MD, Perry, died August 27 at the age of 63. Doctor Barr held three graduate degrees from the University of Michigan, one each in pharmacy, medicine and public health. Doctor Barr was a career medical officer in the US Public Health Service for 20 years, during which time he spent two years in South Vietnam. He served as a medical consultant to the Michigan Department of Social Services for four years prior to his 1982 retirement.

Jose M. Borrego, MD
Grosse Pointe Park

Jose M. Borrego, MD, Grosse Pointe Park, died September 10, 1983. He was 59. Doctor Borrego had been Chief of Anesthesiology at Bon Secours Hospital. A native of Mexico City, Doctor Borrego earned his MD degree in 1948 from the University of Mexico School of Medicine. He was affiliated with Detroit Memorial Hospital, and was a member of the American Society of Anesthesiologists, the American College of Anesthesiologists, and was active in civic groups.

Perry P. Burnstine, MD
Southfield

Perry P. Burnstine, MD, Southfield family physician, died August 11, 1983. He was 83. Doctor Burnstine served the people of the Detroit area for 59 years. He was a 1923 graduate of the Detroit College of Medicine, now Wayne State University School of Medicine. He had been Commander of the Wayne County Jewish Post of the VFW, and was a veteran of both world wars.

John H. Cobane, MD
Grosse Pointe Farms

John H. Cobane, MD, Grosse Pointe Farms, died August 4 at the age of 87. Doctor Cobane was former chief of dermatology at Harper Hospital. He was a 1920 graduate of the University of Michigan Medical School, and was past president of the Michigan Dermatological Society. Doctor Cobane was a life member of the Academy of Dermatology.

Gordon C. Dieterich, MD
Chelsea

Gordon C. Dieterich, MD, Chelsea, died August 8. He was 60. Doctor Dieterich, a psychiatrist, was born in China. He earned his MD degree in 1947 from the University of Kansas. He was a member of the medical staff at Mercywood Hospital, and was affiliated with Glen Eden Hospital in Warren. Doctor Dieterich was a member of the American Psychiatric Association, the Michigan Society of Neurology and Psychiatry and the National Academy of Religion and Mental Health.

John E. Doolittle, MD
South Bend, Indiana

John E. Doolittle, MD, formerly of Niles, died August 8. He was 53. Doctor Doolittle, an obstetrician/gynecologist, was a 1955 graduate of the U-M Medical School. He did an internship at Munson Hospital in Traverse City, then later affiliated with Pawating Hospital in Niles. Doctor Doolittle served as a medical officer in the US Air Force during the Korean Conflict, and was a member of the American College of OB/GYN, and the American College of Surgeons.

Frederick J. Fischer, MD
Detroit

Frederick J. Fischer, MD, Detroit orthopedic surgeon, died August 31. He was 83. Doctor Fischer was well-known for his special rapport with children during his 51 year career in Detroit. He had been chief of orthopedics at Detroit Orthopedic Clinic, Children's, Harper and Hutzel hospitals at various times. Doctor Fischer was a professor emeritus at the WSU School of Medicine, and was a former team physician for the Detroit Lions football team.

H. Maxwell Golden, MD
Flint

H. Maxwell Golden, MD, Flint, died August 31 at the age of 76. Doctor Golden, a native Lithuanian, was a

Continued on page 680

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past president of the Genesee County Medical Society and the Flint Academy of Medicine. He maintained an internal medicine practice for 50 years. Doctor Golden was an associate professor at the MSU School of Human Medicine, and was a board member of the Michigan Heart Association, and president of the Genesee Heart Association. He had been affiliated with Hurley Medical Center, and St. Joseph and McLaren hospitals.

L. Dell Henry, MD
Ann Arbor

L. Dell Henry, MD, Ann Arbor, died July 12. She was 87. Doctor Henry opened the first allergy practice in that city in 1941. At various times during her medical career, Doctor Henry was a U-M instructor of pediatrics, a speech clinic lecturer, a commissioned surgeon in the US Public Health Service, and a bacteriologist with the State of Michigan. Doctor Henry was a 1935 medical graduate of the University of Chicago. She was past president of the Michigan Allergy Society, and had been active in the Red Cross and the Michigan Children's Aid Society.

Stephen Hollander, MD
Grand Rapids

Stephen Hollander, MD, Grand Rapids, died August 25. He was 78. Doctor Hollander did his undergraduate work at Calvin College, then earned his medical degree in 1933 from the University of Michigan. An obstetrician/gynecologist, Doctor Hollander was affiliated with Butterworth, Blodgett and St. Mary's hospitals. During WWII, he served as a major in the Army medical corps as chief of x-ray.

David Leach, MD
Grosse Pointe Woods

David Leach, MD, Grosse Pointe Woods, died July 24 at the age of 77. Doctor Leach was a 1931 graduate of the U-M Medical School. He was on the staff of Detroit Receiving Hospital for more than 20 years, and maintained a private psychiatry practice as well. He taught in the department of psychiatry at WSU, and was a life member of the American Psychoanalytical Association, and the Michigan chapter of that organization. He also was a member of the Michigan Society of Psychiatry and Neurology.

Clinton C. Mills, MD
Philadelphia, Pennsylvania

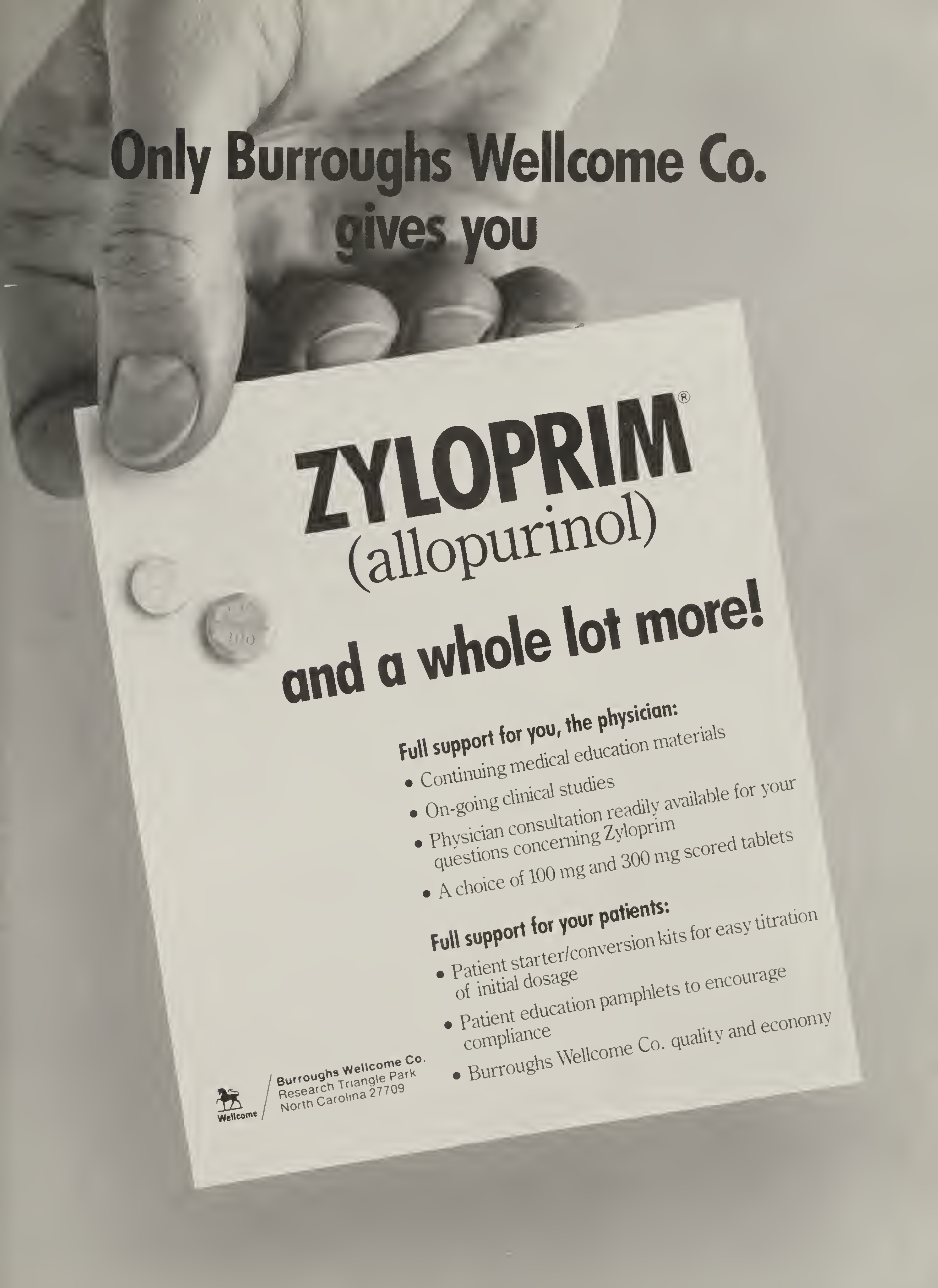
Clinton C. Mills, MD, formerly of Detroit, died August 12. He was 84. Doctor Mills was a general practitioner, and earned his medical degree in 1922 from the University of Michigan. He performed both his internship and residency at Grace Hospital. Doctor Mills had been on staff at Grace and Mt. Carmel Mercy hospitals, and had served as a medical officer for two years during World War II.

Abraham L. Pott, MD
Grand Rapids

Abraham L. Pott, MD, Grand Rapids general practitioner for almost 50 years, died July 22. He was 84. Doctor Pott was born in The Netherlands, and was a 1933 graduate of the U-M Medical School. He received the MSMS 50-year award last May at the House of Delegates meeting in Dearborn. Doctor Pott was affiliated with Butterworth and St.Mary's hospitals before his retirement in 1975. During World War II he served as a Lieutenant Colonel in the medical corps.

Henry K. Ransom, MD
Ann Arbor

Henry K. Ransom, MD, Ann Arbor, died July 23 at the age of 85. Doctor Ransom had served University Hospital and the University of Michigan for 52 years, acting as chairman of surgery for 11 of them. He earned his MD degree there in 1923. Doctor Ransom was a past president and counsel for the Frederick A. Coller Surgical Society; president and founder of the Central Surgical Association; and past president of the Michigan chapter of the American College of Surgeons. In addition, he was a founder of the American Board of Surgery; a governor of the American College of Surgeons; and former chairman of a surgery section of the AMA. In 1968 Doctor Ransom presented gifts to U-M to fund two named professorships in law and medicine.



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MDs liable for locum tenens

The following item is reprinted from the Aug. 1, 1983 issue of "The Citation," a medico-legal digest for physicians published by the AMA. It should serve as an alert for Michigan physicians who arrange for locum tenens coverage while on vacations. It is brought to our attention by MSMS legal counsel A. Stewart Kerr, of Kerr, Russell, Weber of Detroit.

MD may be liable for negligence of MD who covered for him

A physician may be liable for the negligence of a substitute physician who provided vacation coverage, a New York trial court ruled.

A mother took her 11-year-old son to a physician for treatment for a sore throat. Six months later, on June 19, 1979, she returned to the physician's office. A second physician, who was filling in for the vacationing physician, diagnosed the patient's condition as acute gastritis. In fact, he was suffering from appendicitis. He died on June 21, 1979, of a perforated appendix.

The patient's mother and estate filed suit against both physicians. The first physician moved to dismiss the action because he had not treated the patient and the substitute physician was not his employee. A trial court granted a hearing to determine whether the physician was a proper party to the lawsuit.

He testified that he had an oral agreement with the substitute to provide medical services to his patients while he was on vacation.

Reviewing the testimony, the court said that the substitute was not the physician's partner or joint venturer. The substitute was an employee of the vacationing physician, and he could be held liable for the negligence of his substitute, the court concluded. The liability should be imposed because the substitute was standing in the place of and acting for the physician. The court denied the physician's motion to dismiss the complaint. — *Impastato v. DeGirolamo,* 459 N.Y.S.2d 512 (N.Y. Sup. Ct., Jan. 21, 1983)

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By Donald K. Crandall
MSMS president

At the AMA's 1983 Annual Meeting, the House of Delegates approved a recommendation from the Council on Medical Service Report D "that members of the House consider the matter of physician reimbursement by means of indemnity versus UCR with their constituents and other concerned parties over the next six months, communicate any additional views and comments to the Council, and come to the next Interim Meeting of the Association prepared to further express their views on the subject."

The current AMA policy supports the patient's freedom to choose source of care and the physician's freedom to choose method of payment, including fee-for-service, capitation, or salary. Within the fee-for-service approach, current AMA policy supports the basing of third party payment levels on the "usual and customary or reasonable" concept. The question before us is should the Association continue its policy of exclusive support for UCR in the fee-for-service environment, drop its support for UCR completely in favor of indemnity payments, or have a policy supporting several options under fee-for-service?

In studying the AMA Report D, it becomes apparent that there are significant misunderstandings about UCR, indemnity, service benefit and fixed fee schedules. The ills of one are blamed on another, so the whole issue becomes rather confusing. I will try to shed some light on the subject in order to clarify the issue so that we as physicians can make an informed choice.

Basic concept

I would like to start with a basic concept:

SERVICE BENEFIT is to
INDEMNITY
as
UCR is to FEE SCHEDULES

SERVICE BENEFIT is a policy that is sold primarily by Blue Cross-Blue Shield. This is a contract between the carrier and the patient that guarantees that medical services will be provided and paid in full (assuming no co-pays or deductibles). The "providers" of these services (hospitals and physicians) have no say in the type of service, the location of service, or the cost of the service. The carrier must then get providers to accept the carrier's determination of services and costs, to meet their obligation under the contract. This is done with participation agreements or test of performance determinations.

INDEMNITY is a policy that guarantees a certain level of payment for services contracted for between the patient and the physician. In service benefit the policy guarantees services, and in indemnity the policy guarantees payments. In service benefit the insurance company places itself between the patient and the physician by contracting with the physician for the patient. In indemnity, the patient and physician still have a contract, the insurance company only contracts with the patient.

UCR is a mechanism for determining a level of payment. It is used in both service benefit and indemnity policies. UCR is based on the usual, customary, or reasonable charges. With time the formula for determination of UCR has been manipulated so that it no longer reflects usual, customary or reasonable fees. The difficulty with UCR comes only when it is thought to represent payment in full for the service rendered. Under service benefit the UCR is payment in full for participating physicians and the patients. Under the indemnity policy it is not payment in full unless it meets the physician's charge.

FEE SCHEDULES are also a way of determining payment levels. They can be negotiated between parties or determined unilaterally. If they are agreed upon in advance they could be determined as payment in full. If developed unilaterally they would not be payment in full unless they met the charge of the physician.

My understanding of the terms would lead one to believe that service benefit could use UCR or negotiated fee schedules for determination of payment level, as could indemnity policies. The difference is that one professes to supply services, the other a level of payment for the service.

Continued on page 680

MATERNAL HEALTH DESK REFERENCE CARD NO. 1

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

REGIONAL ANESTHESIA IN OBSTETRICS*

*This card replaces and updates the previous Desk Reference Card No. 1 printed 11-1-68.

I. Definitions

Regional anesthesia may be defined as the application of a local anesthetic agent to a nerve trunk causing block of nerve impulses and producing analgesia of the area innervated. Nerve blocks which are most often employed in obstetrics include those which produce peripheral nerve blockade (paracervical and pudendal blocks), and those which cause central neural blockade (spinal, lumbar and caudal epidural blocks).

Infiltration analgesia ("local anesthesia") abolishes pain or prevents the pain of incision by diffusely injecting a given area (e.g. perineum) with a local anesthetic agent.

Relevant Properties of Local Anesthetic Agents

Agent	Useful Concentration (%)	Onset of Action	Duration	MAXIMUM DOSE Without Epinephrine mg/kg	MAXIMUM DOSE With Epinephrine mg/kg
Lidocaine (Xylocaine)	**1.0 -2.0**	**fast**	**medium**	**5**	**7**
Mepivacaine (Carbocaine)	**1.0 -2.0**	**fast**	**medium**	**5**	**7**
Bupivacaine (Marcaine, (Sensorcaine)	**0.25-0.5**	**fast to medium**	**long**	**2.5**	**3**
2-Chloroprocaine (Nesacaine)	**2.0 -3.0**	**fast**	**short**	**12**	**14**

Example: Maximum dose and volume of bupivacaine 0.5% without epinephrine in a 60 kg patient —

60 × 2.5 = **150 mg**

150 (max. dose) ÷ 5 (mg/ml of 0.5% solution) = **30 ml**

II. **General Considerations**

1. No regional anesthetic should be administered without the availability of resuscitative equipment and medication, a source and means to administer oxygen, and equipment as well as personnel to perform endotracheal intubation.
2. It is highly recommended that an intravenous infusion be started using a large bore (16 or 18 gauge) plastic cannula prior to the administration of regional anesthesia. The presence of an intravenous line is mandatory when spinal or epidural anesthesia is employed.
3. Prior to the administration of regional anesthesia, a baseline blood pressure reading in both the supine and lateral position should be obtained. Comparison between the two will reveal if supine hypotension exists.
4. Strict asepsis must be observed when regional anesthesia is employed.
5. Toxic reaction may occur in the mother as a result of unintentional intravascular injection, improper dosage, or injection into a highly vascular area. The person administering the block must be intimately familiar with the recognition and treatment of toxic manifestations.

6. Major regional blocks (spinal, lumbar and caudal epidural) may cause maternal hypotension and may thus adversely affect the fetus.
7. Major regional blocks may also aggravate the effects of aortocaval compression. Very close attention must be paid to proper uterine displacement during labor and delivery (left lateral position, placement of a wedge under right hip, manual displacement, use of mechanical displacers).
8. It is advisable to give oxygen after the administration of regional anesthesia. When a block is given for cesarean section, the administration of oxygen is mandatory.
9. Electronic fetal monitoring is highly recommended during epidural and paracervical block anesthesia.
10. Dosage recommendations listed under each block are general guidelines only. The actual amount of local anesthetic agent used must never exceed the maximum allowable dose (see table above), and should be the smallest amount of drug which will produce the desired degree of block.
11. Contraindications
    - History of true hypersensitivity to local anesthetic agents
    - Patient's refusal or intense fear of regional anesthesia
    - Lack of skill and experience by administrator
    - Infection of puncture site
    - Hemorrhagic hypovolemia
    - Shock
    - Coagulation defects
    - Septicemia
    - Acute neurologic disease

    Spinal and epidural blocks

III. Regional Technics

1. Paracervical Block

Injections are made into the fornices of the vagina lateral to the cervix at 4 and 8 o'clock. A high incidence of transient fetal bradycardia has been reported to be associated with this block. Should it occur, delivery may be delayed until fetal bradycardia recedes so long as immediate delivery is not otherwise indicated. This block should not be used when the fetus is already compromised. Electronic fetal monitoring is considered mandatory.

Drugs and Dosage

Agent	Dose per Injection Site ml
2-Chloroprocaine 1-2% (Nesacaine)	5-10
Lidocaine 1% (Xylocaine)	5-10

2. Pudendal Block

This block is performed in the lithotomy position after the patient has been prepared for delivery. Commonly, the transvaginal approach is employed although the perineal route may be used. Frequent aspirations must be carried out during injection to avoid unintentional intravascular injection. Maternal and fetal effects are negligible.

Drugs and Dosage

Agent	Dose per Injection Site ml
Bupivacaine 0.25-0.5% (Marcaine, Sensorcaine)	10
2-Chloroprocaine 1-2% (Nesacaine)	10
Lidocaine 1% (Xylocaine)	10
Mepivacaine (Carbocaine)	10

B. Cesarean Section

Agent	Single Dose ml	Continuous First Dose ml	 Subsequent Dose ml
Bupivacaine 0.5% (Marcaine, Sensorcaine)	12-20	12-20	8-12
Etidocaine 1% (Duranest)	12-20	12-20	8-12
Lidocaine 2% (Xylocaine)	12-20	12-20	8-12
Mepivacaine 2% (Carbocaine)	12-20	12-20	8-12

5. Caudal Epidural Block

A given amount (see below) of local anesthetic agent is injected into the caudal canal either as a single dose, or intermittently through a catheter. Compared to lumbar epidural analgesia, the amount of drug needed is greater, there is a greater risk of infection and the failure rate is somewhat higher. Unintentional injection of local anesthetic agents into the fetal head has been reported.

Following a negative aspiration test, a test dose of 3-5 ml local anesthetic agent is injected. The remainder of the loading dose is then injected in increments after an observation period of not less than 5 minutes. When a continuous technique is used, subsequent doses are given as needed. Each injection must be preceded by an aspiration test.

Drugs and Dosage

Vaginal Delivery

Agent	Single Dose ml	Continuous First Dose ml	 Subsequent Dose ml
Bupivacine 0.25-0.5% (Marcaine, Sensorcaine)	15-25	15-25	8-17
2-Chloroprocaine 2.0-3.0% (Nesacaine-CE)	15-25	15-25	8-17
Lidocaine 1.0-2.0% (Xylocaine)	15-25	15-25	8-17
Mepivacaine 1.0-2.0% (Carbocaine)	15-25	15-25	8-17

This Reference Card was written for the Maternal and Perinatal Health Committee by Gerhard C. Endler, MD, Detroit, Michigan, September, 1983. References are available from the author.

The above Desk Reference Card describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society and its publication should not be construed as excluding other acceptable methods of handling similar problems.

4. Lumbar Epidural Block

A given amount (see below) of local anesthetic agent is injected into the epidural space either as a single dose, or intermittently through a catheter. An epidural block provides extended pain relief and has superb patient acceptance. Its use precludes the occurrence of post-dural puncture headache unless the needle unintentionally enters the subarachnoid space in which event headache is very likely to occur and may be rather severe. Compared to spinal anesthesia, the onset of analgesia is slower, the failure rate somewhat greater, and hypotension, should it occur, develops slower and is milder. Patients should labor in the lateral position. Close maternal and electronic fetal surveillance is highly recommended. Properly executed, epidural anesthesia has minimal fetal effects. In fact, fetal well-being may be enhanced as epidural anesthesia reduces or prevents maternal hyperventilation and moderates the rise in endogenous catecholamine levels caused by pain, both of which are known to cause reduction in uteroplacental blood flow.

Although the addition of epinephrine to the local anesthetic solution for the purpose of extending the duration and increasing the intensity of the block does not cause a reduction in uterine blood flow, it may produce a decrease in uterine contractility and prolong the first stage of labor.

There have been recent reports of complications associated with lumbar epidural analgesia which occurred when 2-chloroprocaine (Nesacaine) in a dose appropriate to produce epidural analgesia was unintentionally injected into the subarachnoid space causing neurological damage. Similarly, there have been reports of cardiac arrest with difficult resuscitation or death when bupivacaine (Marcaine, Sensorcaine) was unintentionally injected intravascularly. In most cases, this has followed the use of the 0.75% concentration. Thus, bupivacaine 0.75% is no longer recommended for obstetric anesthesia.

A test dose of 3-5 ml of the local anesthetic agent should first be injected and the patient observed not less than 5 minutes for cardiovascular changes, sensory or motor alterations, or CNS toxicity. It is advisable to inject the remainder of the loading dose in increments. Prior to each injection, the proper placement of the needle or catheter must be verified by performing an aspiration test which must yield neither blood nor cerebrospinal fluid. Subsequent doses of about two-thirds the initial dose will maintain the desired sensory level and they are administered in a similar incremental fashion.

Drugs and Dosage

A. Vaginal Delivery

Agent	Single Dose ml	Continuous First Dose ml	Continuous Subsequent Dose ml
Bupivacaine 0.25-0.5% (Marcaine, Sensorcaine)	8-20	8-15	6-10
2-Chloroprocaine 2.0-3.0% (Nesacaine-CE)	8-20	8-15	6-10
Lidocaine 1.0-2.0% (Xylocaine)	8-20	8-15	6-10
Mepivacaine 1.0-2.0% (Carbocaine)	8-20	8-15	6-10

3. Spinal (subarachnoid) Block

A given amount (see below) of local anesthetic is injected through the smallest possible needle (25 or 26 gauge) into the subarachnoid space either in the sitting or lateral position. Injection should never be carried out during a contraction. The block is easy to perform, very quick in onset, and the success rate is very high. Lidocaine 5% provides a block which lasts about 45-75 minutes while tetracaine 1% produces a longer block (about 120 minutes). Duration can be increased by adding 0.3 ml of epinephrine 1:1,000 to the solution.

Hypotension is common and steps must be taken to prevent and treat this complication.

Prevention:

- Prehydration with 750-1,000 ml crystalloid solutions which are devoid of glucose
- Left uterine displacement
- Oxygen
- Continuous monitoring of vital signs, particularly during the first 10-20 minutes.

Treatment:

- All of the above
- Ephedrine in increments of 5-10 mg I.V.

Respiratory impairment can occur when the level of spinal anesthesia rises too high. The level of analgesia should be determined frequently and the patient must be observed most carefully. Treatment consists of ventilatory support.

Post-dural puncture ("spinal") headache occurs with some frequency and, characteristically, improves when the patient reclines and is aggravated by the assumption of the sitting position. Use of a small-gauge needle, adequate hydration, an abdominal binder, or the prone position will reduce its incidence. Treatment includes the above and analgesics. If refractory, homologous epidural blood patch therapy is indicated.

Late neurological complications are very rare.

Drugs and Dosage

A. Vaginal Delivery

Agent	Dose Patient Height 5′0″	 5′6″	 6′0″
Lidocaine 5% (Xylocaine) in dextrose 7.5% in water (premixed)	35mg (0.7 ml)	40mg (0.8 ml)	45mg (0.9 ml)
Tetracaine 1% (Pontocaine) and equal volume of dextrose 10% in water	4mg (0.4ml + 0.4ml)	5mg (0.5ml + 0.5ml)	6mg (0.6ml + 0.6ml)
Total Volume	0.8 ml	1.0 ml	1.2 ml

B. Cesarean Section

Agent	Dose Patient Height 5′0″	 5′6″	 6′0″
Lidocaine 5% (Xylocaine) in dextrose 7.5% in water (premixed) with epinephrine	50mg (1.0 ml)	60mg (1.2 ml)	70mg (1.4 ml)
Tetracaine 1% (Pontocaine) and equal volume of dextrose 10% in water	6mg (0.6ml + 0.6ml)	8mg (0.8ml + 0.8ml)	10mg (1.0ml + 1.0ml)
Total Volume	1.2 ml	1.6 ml	2.0 ml

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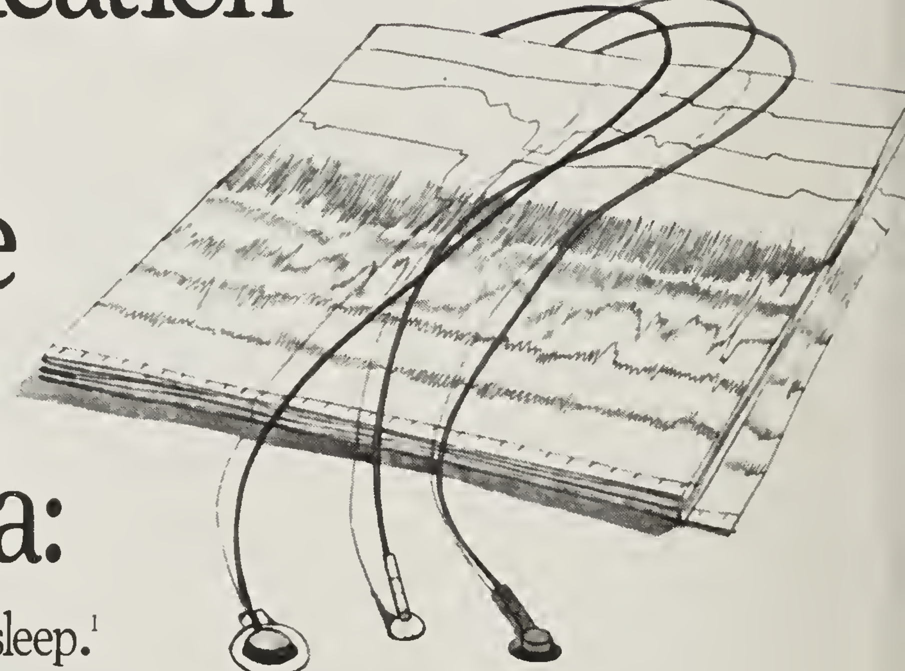

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Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MICHIGAN DELEGATION PREPARING FOR AMA INTERIM MEETING

Future payment systems will be among the foremost topics for discussion and action when the AMA House of Delegates convenes Dec. 4-7 in Los Angeles. Chairman Richard J. McMurray, MD, Flint, will lead the 22-physician Michigan delegation. A report of the Council on Medical Service recommending that payment systems be changed to an indemnity base in lieu of current AMA policy favoring UCR payments, will be before the House for further debate. MSMS surveyed Michigan doctors to gain a grass roots perspective which the delegation will take to the meeting.

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In addition to the official MSMS delegation, at least six Michigan physicians will represent national specialty societies and sections in the AMA House. Also, more than two dozen medical staff representatives from Michigan hospitals plan to participate in the AMA Hospital Medical Staff Section which became active at last June's AMA Annual Meeting. Henry Domzalski, MD, Detroit, is secretary of the new section. MSMS will sponsor three medical students, one each from Michigan's medical schools, and two resident physicians at the meeting.

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Here is every MSMS member's first opportunity to order a copy of the forthcoming 1984 MSMS Roster of Members. The new edition of the biannual publication will feature expanded reference sources and is available to every member free. To reserve your copy of the new roster, please fill out the order form below and return it to MSMS headquarters.

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STATE-LEVEL COMMITTEE SAYS ARBITRATION NEEDS SUPPORT

Although the Michigan Medical Arbitration Program has proved cost-effective and time-saving, it needs the support of a significant majority of health care providers if it is to continue. That is the primary finding of a state-appointed committee which has been evaluating the effectiveness of the arbitration system. The committee, which met Nov. 9 in Lansing, recommended that if the program is retained, it should be mandated in all hospitals. The 18-member group, which includes MSMS representative Rhoda M. Powsner, MD, JD, Ann Arbor, approved five major recommendations of the firm hired to do the actual research. Besides the two recommendations listed above, the committee approved of changing the arbitration agreement to get affirmative declarations from patients to indicate understanding of the program, agreed insurance companies should continue to collect data on malpractice incidents; approved continuing the current makeup of arbitration panels--one attorney, one health care provider and one lay person; and agreed the enabling legislation for the arbitration program should be modified to allow hospital administrations to choose whether or not to offer arbitration agreements in outpatient and emergency room settings.

STATEWIDE NUMBER TO HELP PARENTS WHO ABUSE CHILDREN

Michigan physicians should be aware that a new statewide tollfree telephone number is available to help parents in danger of abusing and/or neglecting their children. The number is 1-800-942-HELP. The parent who needs help can call the tollfree number anonymously and choose the community service which would be most helpful to them. The number is funded by the Michigan Department of Social Services and is staffed by the Drug Education Center in East Lansing. The number is not for reporting suspected cases of abuse or neglect. Persons who wish to report such suspicions will be given the telephone number for the local DSS office. The Drug Education Center in East Lansing also provides statewide tollfree numbers for runaways and domestic violence victims.

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HOUSE AUTHORIZES PPA FORMATION; BILLS MOVE TO SENATE

A six-bill legislative package authorizing insurance companies to make prudent purchaser agreements is under Senate scrutiny after overwhelmingly passing the House Nov. 15. The package of bills is designed to help make health care costs more competitive and to hold down price increases. A "prudent purchaser agreement (PPA)," the new term for preferred provider organization (PPO), is an arrangement whereby organizations may contract selectively with physicians and hospitals for services. Bills HB 4798, 4799, 4800, 4801, 5068 and 5069 permit Blue Cross Blue Shield of Michigan, commercial insurers and dental insurance programs to form PPAs, while HB 5067 permits HMOs to establish PPAs. The bills give consumers two options: one requiring them to use only PPA member providers to get reimbursement, the other providing a financial incentive for going to PPA members but allowing some reimbursement for going to other physicians.

The following legislative actions also are of interest:
1) The Senate Nov. 15 approved a bill banning the practice of surrogate parenting arrangements in Michigan. The bill's future in the House is uncertain, as the representatives earlier rejected legislation regulating the practice.
2) The House passed a bill allowing pregnant minor women to get prenatal medical care without their parents' permission. The bill now moves to the Senate.
3) Nov. 22 was the date of the election seeking recall of Sen. Philip Mastin (D-Pontiac). The possible recall of Sen. Mastin and of Sen. David M. Serotkin (D-Mt. Clemens), whose recall election is scheduled Nov. 29, has legislators nervous about acting on controversies such as seat belts and malpractice.

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MSMS MEMBERS' INSURANCE OPTIONS IN NEW MAILING

MSMS members soon should receive a mailing detailing options in in group health insurance coverage for themselves and employees. The mailing is to go out Nov. 23. Plans available include the comprehensive 94000 group program, a new 80/20 co-pay program and the Dimension 3 deductible/co-pay program. The same programs are available for physicians' employees. New features of the programs include a 180-day pre-existing condition on new enrollees in the employees' group and higher deductibles in the Dimension III program for both individual and family coverage. New area ratings will mean premium reductions for most subscribers. Members who have not received this recent mailing should contact their regional Blue Cross Blue Shield of Michigan office or Wayne Burmeister at MSMS headquarters.

1983 MSMS ANNUAL SCIENTIFIC MEETING DRAWS 1,200 MDs

Approximately 1,200 Michigan physicians are back in practice after attending the 1983 MSMS Annual Scientific Meeting Nov. 15-17 at the Hyatt Regency Dearborn. Several hundred additional course directors, speakers, exhibitors, guests and staff filled the exhibit hall and meeting rooms during the three-day CME event. Particularly popular courses which sold out early included those on low back pain, diabetes, arm pain, basic cardiac life support and hypertension. Annual Scientific Meeting Chairman David R. Rovner, MD, East Lansing and his planning committee members were on hand to monitor courses and gain ideas for the 1984 event, scheduled again at the Dearborn Hyatt Nov. 13-15.

BCBSM NOW REIMBURSES DIABETES EDUCATION UNDER MEDICARE

Services provided on or after Sept. 1 for the Outpatient Diabetes Education Program developed by the Michigan Department of Public Health may be billed to the Medicare Program on the Provider Billing for Medical and other Health Services Form (HCFA-1483). This is according to a recent Blue Cross Blue Shield of Michigan Medicare bulletin. Questions about this new policy may be directed to the Government Provider Inquiry Department at 1-800-482-8760.

MEDIGRAM

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

MSMS BOARD GIVES AMA DELEGATION UCR/INDEMNITY STANDS

MSMS supports indemnity insurance programs. MSMS supports any system which increases physician and patient awareness of the cost of medical services. In addition, MSMS supports payment systems which allow individual physicians to establish their own fees. Those three statements are the closest the MSMS Board could come Nov. 23 to a consensus of members' opinions. The AMA asked all state societies this fall to survey members' reactions to an AMA proposal to abandon the UCR reimbursement system in favor of indemnity insurance programs. The Michigan delegation to the AMA will consider the Board's stands during debate of the issue at the coming interim AMA House of Delegates meeting.

At its Nov. 23 meeting, the MSMS Board also:

1) Adopted the 1984 MSMS operating budget. The 1984 budget shows projected revenues of $2,896,275, and expenses of $2,833,750. The board earmarked part of the 1984 budget for redesigning and reprinting new member kits, for distributing copies of the "Challenge of the 80s" book to new members, and for increasing recruitment of women physicians, FMGs and selected specialties. The Board approved Finance Committee recommendations for augmenting the communications staff with a person who will interpret MSMS actions for target audiences and establish MSMS as the medical information "broker" for the state. The Board loaned the Physicians Review Organization of Michigan up to $91,000 at interest to be repaid within two years from the date PROM starts hospital review operations.

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2) Withheld support of the 1983-87 State Health Plan unless the plan is amended by several MSMS recommendations. In its general comments, the MSMS board said that "if the plan is to be of any value as a guideline for future development, it must offer recommendations based on current trends phasing out regulatory mechanisms and phasing in competitive strategies."

3) Authorized cooperation with the Wayne County Medical Society and other participants to ease enrollment of Medicaid recipients and participation of physicians in the Physician Primary Sponsor Program. MSMS will provide recipients' sign-up forms for interested member physicians to distribute in their offices, while WCMS will offer physician contracts through its offices.

4) Supported legislative bills which would:
    A) Require registration and oversight of weight loss clinics
    B) Waive need for parental consent for minors to obtain prenatal and pregnancy-related medical services.
    C) Provide legal immunity for Board of Medicine members.

The Board opposed legislation which would:
    A) Require referring physicians to inform patients of the

(Continued on back page)

reason for, and cost of, ordered tests.
B) Register and regulate lay midwives.
C) Place amphetamines and methaqualones in the most restrictive class of controlled substances.

5) Called on the MSMS Task Force on Bioethics to develop a position on the "Baby Doe" issue.

8) Enlarged the MSMS Medical Staff Relations Committee to include proposed MSMS Hospital Medical Staff Section officers.

FEDERAL ACTION EXPECTED TO CURB MEDICARE COSTS

Sen. Edward Kennedy was expected, at this writing, to announce a Medicare reform plan. The expected bill, when introduced formally next year, would establish a two-phase program to control health care costs. Phase one would see Medicare Part A (payments to physicians for hospital inpatients) and Part B services handled through the hospital only. In Phase two, a comprehensive payment system covering Medicare and private payers would be established in each state. If a state did not establish a program, the HHS secretary would. Sen. Kennedy says his plan will eliminate a $1 trillion Medicare deficit projected for 1985-2000, without reducing benefits or increasing taxes.

CAPSULES

MSMS members must order their copies now of the 1984 MSMS Roster of Members. Each member is entitled to one free copy but must reserve a copy to receive one. Order forms appear in the Nov. 17 and 24 Medigram issues. Members also may contact Joyce Crum at MSMS headquarters. . . . MSMS members have until Dec. 9 to make changes in their MSMS group health insurance coverage. The open enrollment period extends until that time, rather than to Nov. 30 as announced in recent all-member mailings. . . . The physician's responsibility in suspected cases of child and adult abuse/neglect is described in a new MSMS brochure. Copies are available from Dennis Paradis at MSMS headquarters.

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Vol. 82, No. 56 December 8, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

SOME LEGISLATION SEES ACTION DESPITE RECALLS

MSMS was to be represented by Fred E. Patterson, MD, Ann Arbor, when testimony was taken Dec. 6 on the Senate version of a bill to expand the scope of chiropractic. Doctor Patterson was to testify against the bill before the Senate Health and Social Services Committee. A similar bill got no action after discussion earlier this year by the House Public Health Committee.

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"No action" is the outlook for most legislation of interest to physicians, including the proposed mandatory seat belt bill and the omnibus malpractice bill. That is the result of the two recent recall elections which saw Sens. Philip Mastin and David Serotkin yanked from office by voters angry at their support of the 1983 state income tax increase. Sen. Patrick McCollough (D-Dearborn), sponsor of the omnibus malpractice bill which MSMS supports, is in danger of being another target of recall.

PUBLIC MAY SEE MDs' MEDICARE ASSIGNMENT RATES

Physicians' Medicare assignment rates, listed by counties, are available to the public as a new service of the federal Health Care Finance Administration. The lists have been distributed so far to retiree groups, social security offices, and Blue Cross Blue Shield centers in Grand Rapids, Lansing, Detroit and Marquette. The assignment rate is based on claims for services and supplies provided during the preceding calendar year. In 1982 HCFA required that intermediaries develop the lists, which are prepared July 1 of each year.

THIRD CHANCE: ORDER FORM FOR NEW MSMS ROSTER OF MEMBERS

The 1984 MSMS Roster of Members will be published in January. Each member is entitled to one free copy, but must order below to receive a copy. Additional copies for MSMS members are $10 each. Prices for non-MSMS member physicians, health-related associations, medical schools, libraries, government departments and for-profit corporations appear below. Please tear off this form (your address is on the back) and mail to MSMS, 120 W. Saginaw St., East Lansing, 48823.

_________ I am an MSMS member. (No charge for first copy.)

_________ I am an MSMS member and wish to purchase ______ additional copies at $10 each. (Enclosed is my check or money order for $_______.

_________ I am a non-member MD, or other health care professional. I wish to purchase _____ copies at $30 each. Enclosed is my check or money order for $ _______.

_________ I am with a for-profit corporation. I wish to purchase ______ copies at $150 each. Enclosed is my check or money order for $______.

'TURN-AROUND FORM' MUST BE RETURNED TO MEDICAID

Physicians should complete and return the important Medicaid Provider Enrollment "Turn-Around Form" to continue their eligibility for Medicaid reimbursement. MDs who have misplaced the document mailed Oct. 28 by the Medical Services Administration, Department of Social Services, or have questions on answering specific items should call the Medicaid Provider Enrollment Unit, Lansing, 517/373-7607.

HOSPITAL PHYSICIANS NEED TO REPORT MEDICARE DATA

At the request of the federal Health Care Financing Administration, MSMS reminds hospital-based physicians to provide their hospital administrators with information needed to calculate accurate Medicare reimbursement. The needed information includes frequency and type of services provided and time allocated to Part A and B services. This information will be compiled by the hospital and provided to the Medicare intermediary in Michigan, Blue Cross Blue Shield. The data are required for hospital-based physicians to be reimbursed under the TEFRA regulations.

CAPSULES

Chairman of the AMA Board of Trustees, John J. Coury Jr., MD, Port Huron, will address the luncheon meeting of the Kent County Medical Society Auxiliary March 13 in Grand Rapids. His topic will be current medical care cost containment legislation. . . . MSMS House of Delegates Vice Speaker Robert D. Burton, MD, testified recently in Los Angeles in support of required seat belt use as a better alternative to mandatory air bags and passive restraints. Doctor Burton, chairman of the Michigan Coalition for Safety Belt Use, spoke at one of several regional hearings held by the US Department of Transportation. . . . MSMS hosted the second meeting Dec. 6 of the Professional Associations Group. The group formed in November to make professionals aware of the AMA Prescription Drug Abuse Data Synthesis (PADS) program being tested in Michigan. The group also is interested in whether professional associations have responses to the problem which differ from those recommended by enforcement agencies.

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Whom to call at MSMS headquarters

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Michigan Medicine (MSMS Journal)	Judy Marr
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Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
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Physician Hospital Relations	William Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management	John Anthony
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Public Health	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Committee of Specialty Society Presidents	William Madigan

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Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

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Insurance benefits available for Michigan State Medical Society members

Type	Coverage Available	Special Features	Administrators	Eligibility/How to Apply
1. **Disability Income Protection Accident & Sickness**	Optional amounts up to $1,500 monthly benefit. Benefits paid from the 1st & 16th day, 30th day, or 90th day of disability; and, benefit duration is lifetime for accident and up to age 65 for sickness, depending on the plans selected Coverage automatically includes waiver of premium, accidental death & dismemberment coverage, up to 7 days indemnity for non-disabling injuries, & partial disability payments. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee	New members guaranteed $500 monthly benefit, regardless of medical history Indemnity paid for first 15 days of hospital confinement for sickness. Guaranteed conversion if member leaves the state to continue full time practice in another state. Claims not pro-rated because of benefits received from other insurance.	Stratton-Cheeseman & Associates, Inc 1305 Abbott Road, P O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 75, residing in Michigan, practicing full-time, may apply Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966
2. **Business Overhead Disability Coverage**	Optional amounts up to $3,000 monthly benefit. Reimbursement for office expenses; i e., rent, employees' salaries, utilities, malpractice insurance premiums, etc., during a period of total disability. Benefits payable from the 16th day of disability. Benefits are payable until the Maximum Overhead Expense Benefit Limit is reached — which is the monthly benefit times twenty-four. Waiver of premium is automatically included. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premiums constitute a business expense and are deductible from gross income before taxes (IRS, 55-264, I.R.B. 1955-19, p. 8).	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P O. Box 1563 East Lansing, Michigan 48823	All MSMS members residing in Michigan who practice full-time are eligible to apply Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
3. **Term Life Insurance**	Available in amounts of $25,000, $50,000, $75,000 or $100,000 Renewable to age 70 (amount reduced at age 65). Waiver of premium is included. Full conversion available to the Permanent Life Insurance Plan after policy is in force one year. This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey	New MSMS members guaranteed $25,000, regardless of medical history. Participating members are eligible to share any dividends that become payable Guaranteed conversions to ordinary life if membership is discontinued. Conversions also available to Permanent Life at age 65 reduction and age 70 termination.	Stratton-Cheeseman & Associates, Inc 1305 Abbott Road, P O Box 1563 East Lansing, Michigan 48823	All members, under age 70, active full time in a professional position, are eligible to apply Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan) 1-800-292-1966.
4. **Special Accidental Death & Dismemberment Benefits**	Provides benefits for loss of life, limbs, or sight as the result of an accident in amounts of $25,000, $50,000, $75,000, or $100,000. Coverage for the spouse may be purchased — the amount will be 50% of the member s principal sum. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee	Around-the-clock protection and world-wide coverage. Sports and recreation as well as professional duties are fully covered Renewable to age 70.	Stratton-Cheeseman & Associates, Inc 1305 Abbott Road, P O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 70, engaged full time in their profession in the State of Michigan are eligible to apply Apply to the administrator, Stratton-Cheeseman & Associates. Inc Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
5. **Disability Income Protection For Employees of Members**	Available in various amounts up to $500 monthly benefit. Choice of 7-day, 15-day, or 30-day waiting period for benefits to begin. Two benefit durations available: one-year accident/one-year sickness; and, five-year accident/two-years sickness. Waiver of premium included. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premium is a tax deductible expense when paid by the employer	Stratton-Cheeseman & Associates, Inc 1305 Abbott Road, P O Box 1563 East Lansing, Michigan 48823	Employees, under age 60, who are employed full time by an MSMS member Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
6. **MEDGARD Professional Liability Insurance**	Limits of $100,000/$300,000; $200,000/$600,000, $1,000,000/$1,000,000 available in occurrence policy forms. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan — a physician-owned company	A 75% premium discount to first-year practitioners; 25% discount for second-year practitioners; 50% for most part-time or semi-retired physicians. No charge for P.C./partnership coverage. Premium financing available.	Stratton-Cheeseman Management Company, Inc 1305 Abbott Road, P O Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for a free introductory kit. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550, or toll free (800) 292-1926.
7. **MEDGARD Property & Liability Insurance**	Comprehensive property & liability insurance for physicians' offices and other property. Selection of optional coverages. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan.	Broadest all-risk replacement cost coverage. Insurance designed specifically for physicians. Competitively priced. Advantage of one company — total coverage	Stratton-Cheeseman Management Company, Inc. 1305 Abbott Road, P O Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for specific information. Telephone numbers are: East Lansing (517) 351-1150, Birmingham (313) 647-5550; or toll free (800) 292-1926.
8. **Hospital/Medical/Major Medical Dimension III**	Excellent benefits to cover hospital, medical and major medical services. A separate benefit program is available for employees.	Three option coverages available to physicians and their families, from comprehensive total benefits to Dimension III with deductibles and copayments and a lower premium.	Blue Cross and Blue Shield of Michigan 600 Lafayette East Dept. J113 Detroit, MI 48226	Available to all MSMS members and their employees. Enrollment kit is available from MSMS Department of Member Services, 120 W. Saginaw St., East Lansing, 48823, (Tel. 517/337-1351).

Michigan State Medical Society Membership Insurance Benefits

Are you aware of the insurance available to you as an MSMS member?

On the following two pages is a summary of the member benefit insurance coverages which are available to you through the Michigan State Medical Society. All members are encouraged to review this information to be fully aware of all the benefits available and to determine if and where these coverages may fill a void or supplement your existing insurance program.

Any questions or comments regarding these programs may be directed to Wayne Burmeister, manager, Department of Membership, Operations and Meeting Planning, Michigan State Medical Society Headquarters, 120 W. Saginaw, East Lansing, 48823 (Telephone — 517/337-1351).

Please remove this insert for handy reference in your files.

MICHIGAN MEDICINE

MSMS leaders — as many as we could assemble on Nov. 23, the day of the most recent MSMS board meeting — welcome you to this month's issue. Our focus is on the benefits of being an MSMS member. **Photo by Dick Wesley.**

MICHIGAN MEDICINE

December 1983, Vol. 82, No. 57

Special report

698 Good news — MSMS is growing! The state society's active recruiting efforts to reach resident physicians, medical students and women physicians are spotlighted in this month's special report. Almost the entire issue is given over to MSMS member programs, with our annual light-blue insert on insurance programs leading the way. There are articles here on the MSMS member service subsidiary, the Physician Service Group; and on what's new with the MSMS-founded insurance company, the Michigan Physicians Mutual Liability Company. In this issue are updates on MSMS Auxiliary activities and the annual roster of MSMS members on committees, councils and commissions. Public service materials produced by MSMS and the messages of the annual MSMS Public Affairs/Leadership Conference also are spotlighted; Anna M. Broecker, MD; Robert M. Leitch, MD; Richard H. Gascoigne, MD

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IN MY OPINION

There is no free lunch — but there is a free ride

By R. Jack Chase, MD
Grand Rapids

Doctor Chase

A few of us remember the stories of the old-time saloons that made their money on beer and whiskey sales and gave their patrons a free lunch. Now the free lunch is no more, but there still is a free ride, and many physicians are taking it.

The free ride is being taken by those physicians who do not belong to their local medical society, the Michigan State Medical Society, and the American Medical Association. They ride along enjoying the smooth ride and their fare is paid by their associates who are members. Most of the time these free riders are well-meaning, conscientious physicians who "just never got around to joining," or who "don't believe in medical politics," or those who say "the AMA and MSMS do not represent me, I don't agree with everything they do."

To the latter remark I say, fine; I don't agree with all they do, either. But how much better to join and make your voice heard. How much better to contribute your valuable input to help change medicine for the better. A free rider does nothing to help himself or others in improving the practice of medicine.

One statement we all have heard is that the AMA is predominantly political. Nonsense! The only basis for this is the effectiveness of the AMA in its political endeavors. And look at the AMA budget: Of a total of $77 million in expenditures, $1.5 million is for political education and $1.6 million is required to run the Washington office. That makes a total of $3.1 million for political purposes out of a $77 million budget. The rest is spent in various ways to improve medical care, in publications, meetings, and other medical endeavors.

Let's look at MSMS and the AMA for what they really are: two organizations devoted to providing the best medical care possible and at the same time upholding our profession and its standards. *We need full participation — **your** participation — in our medical societies. We need **your** membership and **your** help.* If you are taking a free ride, join us, buy a ticket. If you have bought your ticket urge others to buy theirs.

You should recently have received your 1984 dues statement for MSMS and AMA. Our dues are proportionately lower than union dues, which are compulsory and do not allow freedom of choice and they offer us a great deal.

I challenge you non-members — yes free riders — to join us. The MSMS and AMA are truly democracy in action, and more bipartisan than you can imagine. Their primary goals are to provide the best medical care in the world and to preserve free enterprise in medicine.

Buy a ticket for a worthwhile ride.

Doctor Chase is chairman of the MSMS Task Force on Medical Care Costs.

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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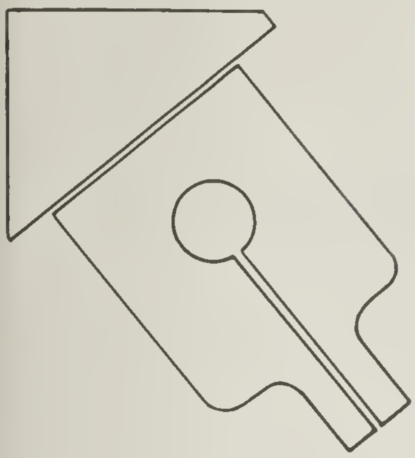
LETTERS



UCR vs. indemnity

In the October issue of *Michigan Medicine,* MSMS asked for members' responses to a report by the AMA Council on Medical Service calling for an indemnity form of health insurance in place of physician payment by the usual, customary and reasonable (UCR) charge. In the November issue of *Michigan Medicine,* MSMS President Donald K. Crandall, MD, said he believes that AMA Council has confused types of insurance policies with mechanisms for determining levels of payment. Here are other members' responses to the AMA's proposal:

"This is probably a good idea, but I am not certain of the mechanics of it. Based on risk factors and amount of premium, would it pay for hospital admissions? for hospital visits? for obstetrical care? for removal of a wart? etc., etc."

"Where does psychiatry fit in? The "UCR" is about $75 to $85. However, BCBSM recognizes $54.25 after six years of $49! There actually are some companies that say $20 is a UCR. The practice of psychiatry is hard enough as it is — what can you do to help?"

"I agree. It would seem to make fees more responsive to market pressures. It would make patients (consumers) more concerned and involved in cost control. It would aid recognition of the fact that providers alone cannot control costs."

"I agree. Health care costs will be better kept in line through free market forces than through third party insurance or government decree."

"I disagree. While AMA leaders feel reimbursements are inadequate, the fact is that the average income of physicians is nearly $80,000 a year.

"The underlying reason for pushing the change is that nonparticipating physicians are embarrassed to ask for more and need larger staffs if they do so. These nonparticipating physicians want the onus of their demands removed, and want other physicians to have the large staffs and expense that nonparticipating physicians must bear.

"The change is not politically feasible. Patients on Medicare to whom I have talked on this subject do not take kindly to the idea. That Medicare would not take responsibility for 80 percent of their medical costs means that these individuals would have to pay more from their fixed incomes. The elderly would put up a terrific fight to prevent that step from occurring."

"Strongly agree. Third party carriers are controlling medicine now."

Group insurance

I read with glee your MSMS Board actions concerning insurance (Sept. 22 *Medigram).* I . . . dislike filling out (Blue Cross Blue Shield of Michigan) forms and had planned to switch to another health insurance at the end of the year even though it might cost me twice as much for the same coverage. I have called several companies and did take out an AMA catastrophic health and accident policy.

I eagerly await further information concerning a new group carrier for the society and would even go ahead with an interim policy with that company until such a change is made by the society.

R. W. Phillips, MD
Whitmore Lake

Seatbelt design

I have read with interest the material in the October issue of *Michigan Medicine* concerning seatbelt usage.

It occurs to me that another 30 percent or so of the population might spontaneously and without urging of any kind use them faithfully if the car makers could be *forced* to design them so they fitted.

As an example: I am a small, slender build. The upper attachment of the shoulder harness is set so high that the belt rides across my neck and under my arm instead of across my chest.

Until two years ago I drove a Dasher which very simply and easily solved the whole problem by having *two* attachment sockets; the car came with the belt attached into the upper one, but upon request the dealer promptly re-attached it to the lower, thus bringing the belt down to lie comfortably. I wore the belt consistently, until the next trade-in.

My present car has the same old problem. I asked the dealer to custom-design a second attachment, but he refused, using the excuse that "it probably wouldn't conform to federal safety rules, etc., etc."

I prefer to wear a seatbelt, but what can I . . . and perhaps many thousands of others . . . do? I suspect a "steering wheel injury" is to be preferred to quadriplegia due to seatbelt. But I really don't relish the thought of either one. Cannot pressure be brought to bear so federal standards *require* adjustment?

A. C. Worden, MD
Marquette

P.S. Please do not suggest pulling the seat a little further forward, those of us with this problem already have it locked in at the furthest forward notch anyway.

SPECIAL REPORT

Good news! MSMS membership is growing!

By Anna Broecker, MD
Grand Rapids

MSMS is growing!

As a member of the MSMS Committee on Membership Recruitment and Retention I am delighted with the effort of our organization to attract new members.

Last year we passed the 10,000 mark in MSMS membership. As of this writing, MSMS numbers 10,342 members in all categories. And because of the student, resident and AMA direct-joiners who boosted Michigan's AMA direct-joiners who boosted Michigan's AMA membership, MSMS was able to add an eleventh AMA delegate this year. The AMA grants one delegate for every 1,000 AMA members in a state (or fraction thereof), so the 10,001st member automatically adds that delegate.

Hallmark commitment

Our greatest growth currently is in the student and resident category. On October 31 of last year we counted 49 resident members and 74 student members. As of October 31, 1983 we're pleased to have 195 resident members and 217 student members. And, I might add, there are at least another 200 of these members now in the processing phase who we will welcome by the year's end. That's exciting!

What also is noteworthy is the fact that a substantial number of these new members are joining organized medicine on all levels, from local to national. It is that kind of commitment that I see as the hallmark of our upcoming young physicians.

I have a concern to see more of our state's female doctors brought into membership. From the best information we can gather there are 1,371 female physicians in the state; currently 669 of them, or 49 percent, belong to MSMS. Some 535, or 39 percent, belong to the AMA. The three of us female members of the membership committee see a special challenge in our own ranks which we are eager to address in the coming months.

Another important segment of our physician population to work on is our foreign medical grads. At the end of last year there were 3,654 FMGs in Michigan, and 2,580 of them held membership in MSMS. That means 25 percent of the FMGs are not members. It also means that 29.6 percent of the MSMS membership (exclusive of retired and life members) is foreign-trained. This compares with the national average of approximately 21 percent.

MSMS is preparing a more detailed analysis of the FMG membership which will be shared with all of us shortly.

Through the end of October, MSMS had processed some 628 new member applications, compared with 573 for all of last year. When reinstatements are placed back on the roles, the net loss for moves and non-dues payers will be only 45 this year, compared with 150 last year.

As they say in accounting, the bottom line is that we currently show a net gain of 367 members thus far this year compared with a net gain of only 150 in all of last year. And that is good news.

Aggressive campaign

Your membership committee, working with our staff and leadership, is embarking upon an aggressive membership campaign. We are not ready to rest on our laurels or past achievements. Nor are we basking in the glow of a strong showing at the moment. We fully realize there is much serious work to be done and more members out there to be brought into the ranks.

Michigan currently ranks third in market share percentage of physician members among those states having 10,000 or more doctors. Our hope is to move up in the standings.

Your membership committee is working aggressively. We need each of you to work with us by encouraging non-member physicians you may know to become part of us. And those of you who are not members of the AMA can do your part by joining on the top level, as together we show our support for the AMA. Its chairman of the Board of Trustees this year is none other than our own John Coury, MD, Port Huron, a distinguished past president of MSMS.

Doctor Broecker is vice chairman, MSMS Committee on Membership Recruitment and Retention.

On Nov. 23, MSMS leaders gathered at MSMS headquarters for a formal portrait. From left in the front row are Donald K. Crandall, MD, Muskegon, MSMS president; Thomas R. Berglund, MD, Portage, chairman of the board; Carl A. Gagliardi, MD, Dearborn, board vice chairman, and Louis R. Zako, MD, Dearborn Heights, MSMS president-elect. Immediately behind officers, from left, are Jack L. Barry, MD; Donald N. Sweeny Jr., MD; Kenneth L. Ray, MD; Marguerite L. Shearer, MD; Busharat Ahmad, MD, and Frederick Bryant, MD. In third row, from left, are Justin L. Sleight, MD; Gerald H. Mandell, MD; Harvey M. Andre, MD; Frank B. Walker II, MD; Robert E. Paxton, MD; Robert M. Leitch, MD, and Robert D. Burton, MD. In back row from left are Leland E. Holly II, MD; Billy Ben Baumann, MD; Kenneth B. Herrington, MD; James J. Humes, MD; Kornelius Van Goor, MD, and Joel W. Clay, MD. Not pictured are James H. Tisdel, MD; Richard McMurray, MD; Arthur A. Ulmer, MD; William D. Walters, MD; Richard L. Rapport, MD; Vickers C. Hansen, MD; Charles L. Oppy, MD, and Kenneth E. Rowe, MD.

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President-elect	Louis R. Zako, MD, Dearborn Heights
Immediate Past President	James H. Tisdel, MD, Port Huron
Secretary	Robert M. Leitch, MD, Battle Creek
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District 11	Robert E. Paxton, MD, Fremont
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District 14	Marguerite Shearer, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac Frederick W. Bryant, MD, Royal Oak Joel W. Clay, MD, Mt. Clemens

What's new with MPMLC?

By Robert M. Leitch, MD
Battle Creek

In dynamic organizations such as Michigan Physicians Mutual Liability Company, new things are occurring constantly. They range from minor changes in inhouse management of day to day business to major changes in philosophy at the senior management and board level.

One of our principle concerns now is the lack of awareness or concern of some physicians about the rapidly escalating severity of the professional liability situation. We are attempting to correct this problem. We anticipate increasing the number of issues of "Mutual Monitor," our regular newsletter. The focus of much of the material in the "Mutual Monitor" will be on heightening physician awareness of the problems they are facing.

Surprised reaction

Michigan Physicians has developed a program for presentation to component medical societies, hospital staffs, and others on some of the pitfalls which are causing current professional liability problems. This program has been presented in a number of communities from Ann Arbor to Petoskey, and will be presented over the remainder of the fall and winter months.

To date the program has been well-received; the reaction seems to be surprise at the magnitude of the problem. If only a few malpractice suits are prevented by the increased awareness generated by the program on the part of our insured physicians, it will have a positive effect. Each suit, even those which we win, creates a severe expense to the company.

Other MPMLC activities in the risk management area include research to identify physicians at high risk of medical malpractice suits, and development of an audit system and training program to decrease the degree of risk of these physicians. We are consulting with experts at the University of Michigan and hope to have a program developed within the near future.

We are considering a survey of former plaintiffs in malpractice actions against MPMLC to determine, where possible, the principle factor which caused them to bring suit. Such information could help us develop a loss control program which might decrease future claims.

Because of the increase in the size of the premiums and the hardship which this increase presents, we have developed a new monthly financing program, in addition to the current semi-annual and quarterly programs. We believe this payment option will appeal to those who prefer to budget payments on a regular basis.

As the number and size of awards and settlements increase, we are markedly increasing our activity in the area of structured settlements. This has increased to the magnitude that we now have a full-time employee at Michigan Physicians to develop the structured settlement proposal and to participate in the conference for completing the particulars of the settlement.

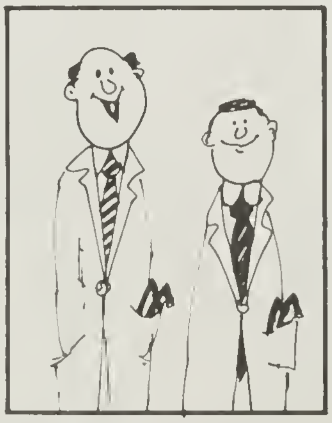
$1,000,000 settlement

Although increasing numbers and amounts of awards and settlements are not new, we passed a recent milestone at the October meeting of the Claims Committee. Then, we offered $1 million in settlement of a claim for the first time. We hope this is one "new" activity which is not repeated on a regular basis.

These are a few of the new and timely things at MPMLC. We have an active, dedicated staff, eager to stay abreast of the new developments in this area and to implement them where feasible. They will institute innovations which will allow us to provide the best, most comprehensive, economical service to our policyholders as possible. Only by so doing will we be able to maintain our position as the number one medical professional liability insurer in the state of Michigan.

Doctor Leitch is president of the MPMLC.

I know that there are many great benefits to being a member of MSMS.



. . . the journal, *Michigan Medicine* . Group Insurance . A great lobby . CME programs . . . organized leadership . . etc etc.

MARK CAMPBELL

But what's this about having to pay membership dues???

MSMS/PSG provides variety of member services

There are many products and services on the market which can help the physician run a medical practice more smoothly and efficiently.

But how does the physician distinguish which are readily available, economical and of good quality?

That is where the MSMS Physician Service Group, Inc., comes in. The PSG's objective is to increase the economic well being of Michigan physicians, both in their business and personal life.

Another PSG objective is to aid the physician by making available tools and resources of reasonable cost and constant quality.

Here are some of the services provided:

(1) Practice management consultations (profiled in the major article of this section) and seminars. Seminars are offered to residents about to establish themselves in practice and for physicians who have been serving patients for years.

(2) Bill collecting services. The PSG endorses the I.C. Systems Collection Company for use by physicians in collecting indebted accounts. Since the PSG endorsed IC Systems in 1980, the company has collected over $6,000,000 for Michigan physicians. Currently, over 2,000 physicians take advantage of this program, at a cost substantially below other collection companies' charges.

(3) Credit card service. The MSMS/PSG Credit Card Program has 350 MSMS members enrolled, allowing patients to pay bills by credit card. PSG collects the payments and every two weeks sends the physician a check for the appropriate amount, less a small administrative charge. This system reduces physicians' costs in sending out statements and in office collection efforts.

(4) Administrative services. The PSG provides office staff for several Michigan physicians' and other health care professionals' organizations. This includes member records, arrangements of major meetings, staffing for committee and general membership meetings, and newsletter services.

The MSMS Physician Service Group considers many factors when offering new services or endorsing products and services for MSMS members. These include:

(1) The overall contribution to the smooth and efficient running of a physician's practice.

Physician
Service
Group, Inc.

(2) The ability of the service or product to meet a large number of the physician's needs.

(3) The availability of the services to physicians throughout the entire state.

(4) The organization's background in the field.

(5) Its experience in dealing with physicians in the past.

(6) The PSG can provide physicians with practice building techniques (such as patient information brochures which inform new patients of location, office policy and services provided). PSG consultants will analyze your practice, determine its strengths and recommend measures aimed at making those strengths known to patients in the area.

(7) MEDI-LEASE is a capital equipment leasing plan administered by Barnhill Philip Services, Inc., of Mason, Michigan, designed exclusively for MSMS members. One unique feature is the pre-arranged lease line of credit for each physician who applies for a MEDI-LEASE card and meets the credit requirements. There are many advantages to leasing, some of which affect the productive potential of money and suggest that leasing may be the most cost effective method of financing acquisitions of equipment for business use.

(8) PSG markets the GTE Medical Information Network (MINET) to Michigan health professionals. The Medical Information Network is an electronic communication and information system which can be accessed over telephone lines from virtually any computer or terminal equipped with communications capability. A user dials a local telephone number, plugs into an accoustical coupler (or connects directly via modem), signs onto the system using codes supplied by PSG and enters the world of electronic communications and information retrieval.

Here is what the GTE/MINET network offers. The system features six AMA/NET data bases that are licensed and maintained by the AMA. These data bases are:

(1) Drug information, (2) Disease information, (3) Socio-economic bibliographic information, (4) MGH — Category I CME credit offerings of the Massachusetts General Hospital, (5) EMPIRES — a biomedical bibliographic information base, and (6) CPT — medical procedure coding and nomenclature. In addition, an electronic mail system — MED/MAIL — offers instant transmission of written messages between subscribers.

For further information regarding the AMA/NET information services and GTE Telenet Medical Information Network, please contact Ellen Vinocur Potash at (517) 337-1351.

‘Your doctor cares’ theme of MSMS public service efforts

By Richard Gascoigne, MD
Adrian

Challenge of the 80's
Improving Your Practice in Today's Competitive Climate
A workshop/Seminar for Physicians offered by the Mich. State Medical Society
Challenge of the 80's
HAS ANYONE CALLED THE DOCTOR
THE ABUSED PATIENT
LIFE
BUCKLE UP

Since 1980, when the MSMS House of Delegates approved the financing and implementation of a strengthened public relations program, MSMS has been actively working on public and member programs designed to help both groups.

To establish a base providing a measure of public and member understanding, MSMS conducted an attitudes survey. This survey, professionally done by an outside polling firm, indicated that the public had, for the most part, a generally positive opinion for and reaction to physicians and medicine.

It showed, however, that there was a need to present medicine and the profession in a positive light on a regular basis if public opinion were to be maintained.

The survey also showed some minor discrepancies between what the public perceived on various questions and issues and what physicians thought the public thought about the same issues.

Perhaps the most important point to come out of the survey was the theme for the MSMS effort, “Your doctor cares.” All efforts undertaken since have been built around this theme.

To review for members the scope of the PR effort, *Michigan Medicine* will carry over the next several issues detailed accounts of the various programs undertaken. Many of the programs continue, and the materials can be utilized by members in their own patient relations efforts.

Here is an overview listing of the programs to be detailed in coming months:

1. **“Has Anyone Called the Doctor?”** A 27-minute cable TV program.
2. **“If Illness or Injury Strikes”** A basic first aid guide for travelers.
3. **“If Someone in Your Family Wants to be a Doctor . . . ”** A patient relations folder explaining what a doctor is and how he/she became one in terms of education, training and licensing.
4. **“Protect Your Eyes”** An eye safety poster for court sports.
5. **“Buckle Up! Your Doctor Cares”** Buttons and bumper stickers on seat belt safety.
6. **“Public service TV spots”** A series of four messages on getting a doctor, immunizations and medical care costs.
7. **“News of medicine”** An ongoing series of news feature articles on medical topics and specialties for Michigan newspapers.
8. **“Coping with Stress”** A poster developed for the workplace as a joint effort between MSMS and the Michigan Psychiatric Society.
9. **“Ask the Doctor”** TV programs — MSMS continues to develop and support local call-in television programs around Michigan.
10. **“Challenge of the 80s”** A book and series of seminars for MSMS members to help them deal with competition and run an efficient practice, and to assist them in better patient and public communications.

Watch future issues for our “PR corner” which will tell about each of these programs in greater detail. Many of the materials and folders are available to members who would like to use them in their offices with their patients. The series also will offer tips, ideas and suggestions for improving patient relations.

Doctor Gascoigne is chairman of the MSMS Committee on Public Service.

Before and After

Before delivery, **Anusol® Ointment*** rapidly, temporarily relieves the itching, burning, and pain of hemorrhoids of pregnancy and other anorectal disorders. Used concomitantly, **Tucks® Pads** add cooling, soothing comfort to tender anorectal tissues. **Tucks** also serve as a hygienic rectal wipe, gently cleansing away potentially irritating fecal residue.

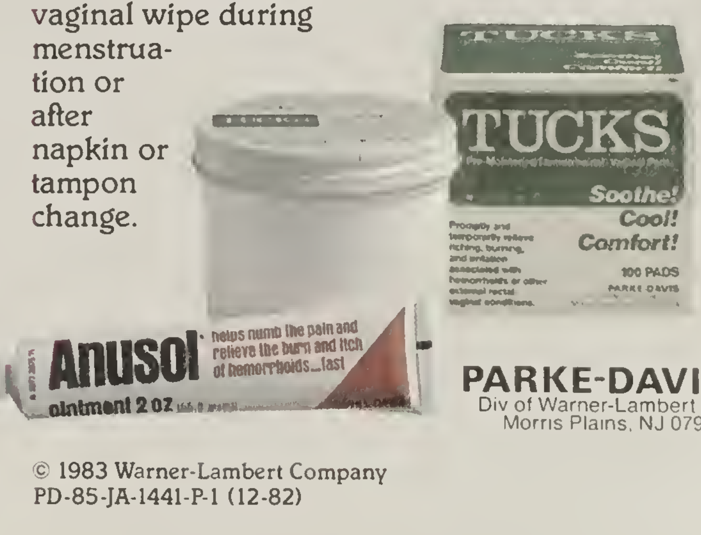
THEY WORK SO WELL TOGETHER!

***Anusol Ointment contains PRAMOXINE HCl–a non-"caine," topical anesthetic derived from morpholine and generally recognized as safe and effective for external use. Pramoxine is as potent as benzocaine but appears to be less sensitizing. Its distinct structure tends to minimize the risk of cross-sensitivity. Pramoxine acts within three to five minutes, and its anesthetic effect can last as long as several hours. In addition, Anusol Ointment contains emollient, lubricant, wound-healing, and protectant ingredients.**

After delivery, **Anusol Ointment** and **Tucks Pads** work well together to maintain their complementary relief of postpartum hemorrhoids.

After episiotomy or other vaginal/rectal surgery, **Tucks** serve also as an ideal hygienic wipe or wet compress.

In nonpregnant women, Tucks are a useful vaginal wipe during menstruation or after napkin or tampon change.



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Soothe! Cool! Comfort!
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Anusol
helps numb the pain and relieve the burn and itch of hemorrhoids...fast
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MSMS committees — their purposes, their members, and their staff assistants

Committee on Aging

This Committee examines the status of senior citizens and advocates good health, preventive medicine programs, and adequate care for those who survive longer because of advances in medicine. It strives to revitalize local committees on aging.

William T. Bateman, MD, Chairman, Kalamazoo
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David H. Deitrick, MD, Muskegon
Russell W. Holmes, MD, Lansing
Kurt Kratz, WSU
Thad Laird, MSU
Patricia M. Perry, Ann Arbor
Timothy J. Tobolic, MD, Byron Center
Richard H. Wakulat, MD, Petoskey
Dennis M. Paradis, Staff Assistant

Steering Committee on Program to Assist Impaired Physicians

The Steering Committee provides assistance to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

Carl A. Gagliardi, MD, Chairman, Dearborn
Robert H. Hydrick, MD, Grand Rapids
Joyce W. Mason, MD, Ann Arbor
Stephen C. Mason III, MD, Ann Arbor
Robert Niccolini, MD, Detroit
Ward M. Smathers, MD, Lathrup Village
Justin L. Sleight, MD, Lansing
Russell F. Smith, MD, Whitmore Lake
Katie Brewbaker, Staff Assistant

Committee on Awards

This Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

Justin L. Sleight, MD, Chairman, Lansing
Robert M. Leitch, MD, Battle Creek
Frank B. Walker, MD, Grosse Pte. Farms
Katie Brewbaker, Staff Assistant

Task Force on Bioethics

The Task Force considers questions about scientific, medical, moral, ethical and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and therefore MSMS.

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Jeffrey S. Crumbaugh, U/M
James T. Harrison, MD, Lansing
John V. Hartline, MD, Kalamazoo
Sue A. Officer, MSU
Evan J. Reinders, MD, Muskegon
Marguerite Shearer, MD, Dexter
Kornelius Van Goor, MD, Grand Rapids
Lester Weiss, MD, Detroit
Sherry N. Wellman, Staff Assistant

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Arthur A. Ulmer, MD, Grosse Pte. Shores
Richard M. Campau, Staff Assistant

Committee on Child Abuse and Neglect

The MSMS Committee on Child Abuse and Neglect was established as a focal point for medical concerns related to child abuse. Its purpose is to increase physician awareness about the problems of child abuse and to initiate or participate in programs to promote the detection and reporting of child abuse.

Brooker L. Masters, MD, Chairman, Fremont
Alexa Canady, MD, Detroit
Susan Cline, U/M
Mrs. Dottie Csonka, Essexville
Ray E. Helfer, MD, East Lansing
Ann L. Hammon, WSU
Ruben S. Kurnetz, MD, Birmingham
Barbara Meyer Lucas, MD, Detroit
Douglas A. Sargent, MD, Grosse Pte. Farms
Jack M. Stack, MD, Alma
Natalia M. Tanner, MD, Detroit
Mark H. Tucker, MD, Battle Creek
Dennis A. Wagner, MD, Sanford
Dennis Paradis, Staff Assistant

Committee on Continuing Medical Education Accreditation

This Committee maintains standards to assure that quality CME activities are available to Michigan physicians, through review, evaluation, and accreditation of continuing medical education providers in the state.

Donald J. Aiken, MD, Chairman, Okemos
Richard F. Willis, MD, Alpena

Continued on page 709

The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city. . .in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet
Medical Information Network

GTE

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A member service subsidiary of the
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EAST LANSING, MICHIGAN
ELLEN VINOCUR POTASH
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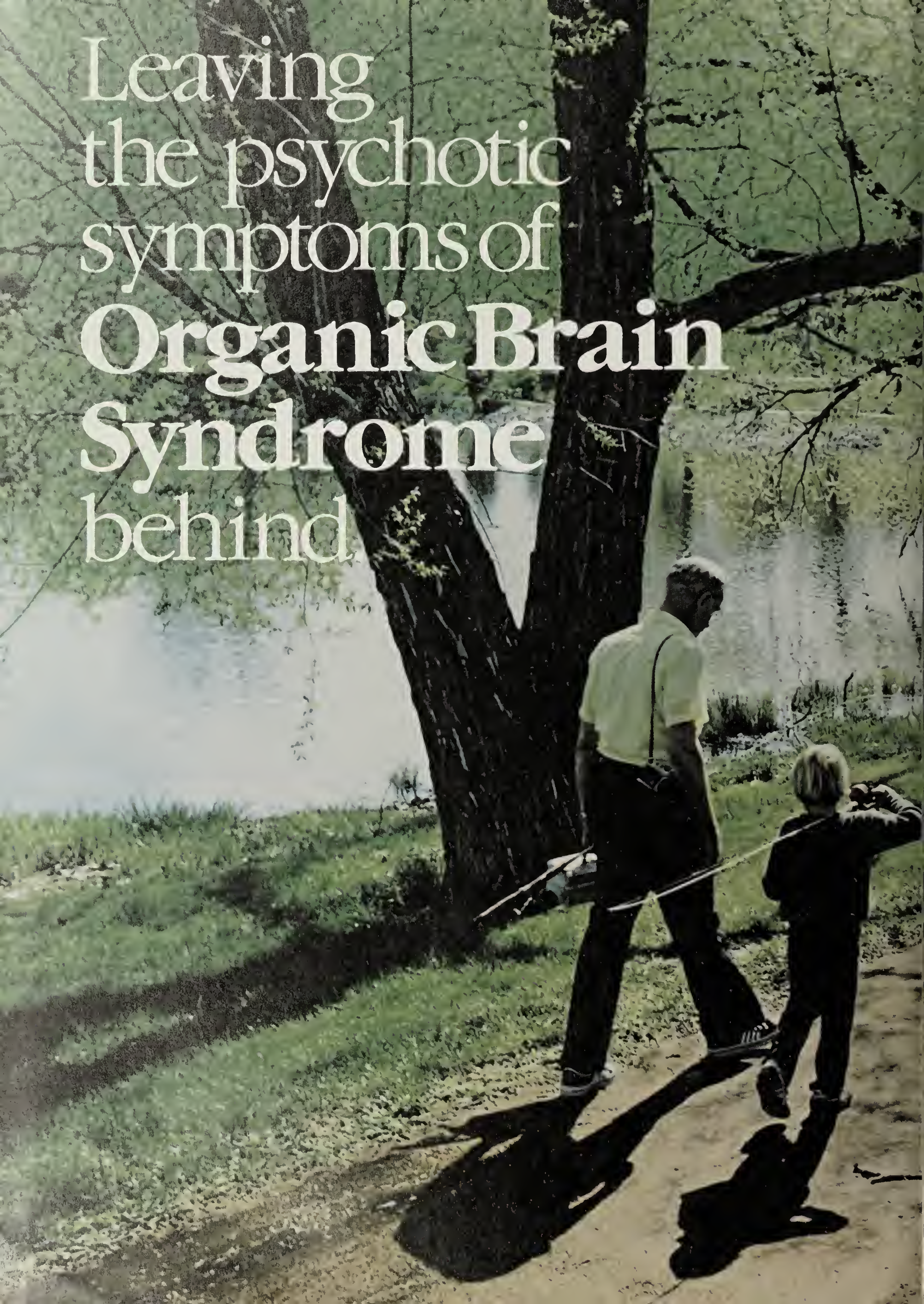
Leaving the psychotic symptoms of **Organic Brain Syndrome** behind

Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

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Navane®

(thiothixene) (thiothixene HCl)

References 1 Util TM, Unverdi C. Wohlrade J, et al Drug therapy of psychosis associated with organic brain syndrome Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16. 1972 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology *Arch Gen Psychiatry* 31 204-210, 1974 3 Ketai R Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58 87-93, 1975. 4 Birkett DP, Hirschfield W, Simpson GM Thiothixene in the treatment of diseases of the senium *Curr Ther Res* 14 775-779, 1972 5. Data on file at Roerig

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BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias Navane is contraindicated in individuals who have shown hypersensitivity to the drug It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered

Warnings: *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects

In the animal reproduction studies with Navane there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen (See Precautions)

Usage in Children – The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy Therefore, the patient should be cautioned accordingly

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma or who might be exposed to extreme heat, or who are receiving atropine or related drugs

Use with caution in patients with cardiovascular disease

Also, careful observation should be made for pigmentary retinopathy and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods) Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice biliary stasis) have been reported with related drugs

Undue exposure to sunlight should be avoided Photosensitive reactions have been reported in patients on Navane

Neuroleptic drugs elevate prolactin levels, the elevation persists during chronic administration Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis, the available evidence is considered too limited to be conclusive at this time

Intramuscular Administration – As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle The preferred sites are the upper outer quadrant of the buttock (i e gluteus maximus) and the mid-lateral thigh

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury Intramuscular injections should not be made into the lower and mid-thirds of the upper arm As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel

Adverse Reactions: *Note* Not all of the following adverse reactions have been reported with Navane (thiothixene) However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used

Cardiovascular effects Tachycardia, hypotension, lightheadedness, and syncope In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result Nonspecific EKG changes have been observed in some patients receiving Navane These changes are usually reversible and frequently disappear on continued Navane therapy The incidence of these changes is lower than that observed with some phenothiazines The clinical significance of these changes is not known

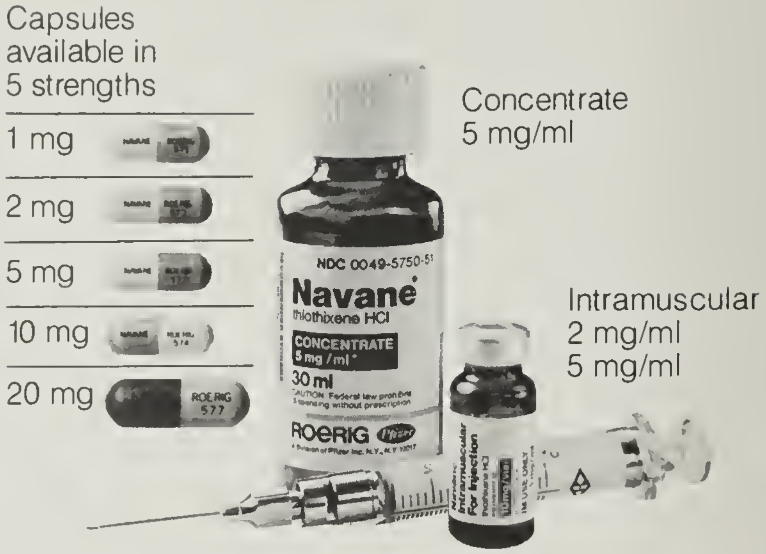
CNS effects Drowsiness, usually mild, may occur although it usually subsides wtih continuation of Navane therapy The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines Restlessness, agitation and insomnia have been noted with Navane (thiothixene) Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities

Extrapyramidal symptoms such as pseudo-parkinsonism, akathisia, and dystonia have been reported Management of these extrapyramidal symptoms depends upon the type and severity Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent

Persistent Tardive Dyskinesia As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g , protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia, antiparkinsonism agents usually do not alleviate the symptoms of this syndrome It is suggested that all antipsychotic agents be discontinued if these symptoms appear

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported

Hematologic effects As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia

Allergic reactions Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane Undue exposure to sunlight should be avoided Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria

Autonomic effects Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus

Other adverse reactions. Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response

Some patients have been successfully maintained on once-a-day Navane therapy

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established

Navane Intramuscular Solution: Navane For Injection – Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily Dosage may be increased or decreased depending on response Most patients are controlled on a total daily dosage of 16 to 20 mg The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs

Navane Capsules Navane Concentrate – In milder conditions, an initial dose of 2 mg three times daily If indicated, a subsequent increase to 15 mg/day total daily dose is often effective

In more severe conditions, an initial dose of 5 mg twice daily

The usual optimal dose is 20 to 30 mg daily If indicated, an increase to 60 mg/day total daily dose is often effective Exceeding a total daily dose of 60 mg rarely increases the beneficial response

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma

Treatment Essentially is symptomatic and supportive For Navane oral, early gastric lavage is helpful For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage If hypotension occurs, the standard measures for managing circulatory shock should be used (I V fluids and/or vasoconstrictors)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate Stimulants that may cause convulsions (e g picrotoxin or pentylenetetrazol) should be avoided Extrapyramidal symptoms may be treated with antiparkinson drugs

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication

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Committee on Continuing Medical Education Programming

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Committee on Constitution and Bylaws

This standing Committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

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Committee on Federal Legislation and Related Matters

This one-man Committee works in cooperation with the Washington, DC, office of the American Medical Association.

Richard J. McMurray, MD, Chairman, Flint
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Steering Committee on Health Planning

This Committee recommends MSMS policy on health planning. It encourages physician involvement in health planning issues, monitors activities of health systems agencies (HSA) and the Statewide Health Coordinating Council (SHCC) and assures physician input.

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Task Force on Home Health Care

The Task Force oversees the growth of the home health care industry and provides medical input when appropriate. The advent of DRGs promises to release sicker patients to non-hospital settings thereby fueling the growth of this industry.

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Committee on Humanitarian Services

This Committee identifies areas where MSMS may use its influence at the state, national, or international level to improve the public's health and increase the awareness of MSMS membership about current humanitarian services involving members of organized medicine.

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Task Force to Improve Component Society Relations

This Task Force seeks to improve working, cooperative relationships with components, their officers and executives, by encouraging or developing visitation programs by involvement in special seminars or through special program segments of the MSMS Public Affairs Leadership Conference. It also determines components' needs and makes recommendations to the Board of Directors for fulfilling those needs.

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Judicial Commission

The Commission has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

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Liaison Committee with Auxiliary

The Liaison Committee advises the MSMS Auxiliary, on request, regarding Auxiliary activities and problems. It also suggests projects the Auxiliary may wish to undertake.

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Lawrence E. Grennan, MD, Muskegon
John R. Ylvisaker, MD, Bloomfield Hills
Fikria B. Hassan, MD, Advisor, Flint
Caroline A. Rich, Staff Assistant

Liaison Committee with Medical Assistants

The Liaison Committee advises the American Association of Medical Assistants, State of Michigan, on request, regarding medical assistant activities and problems. It also suggests projects the medical assistants may wish to undertake.

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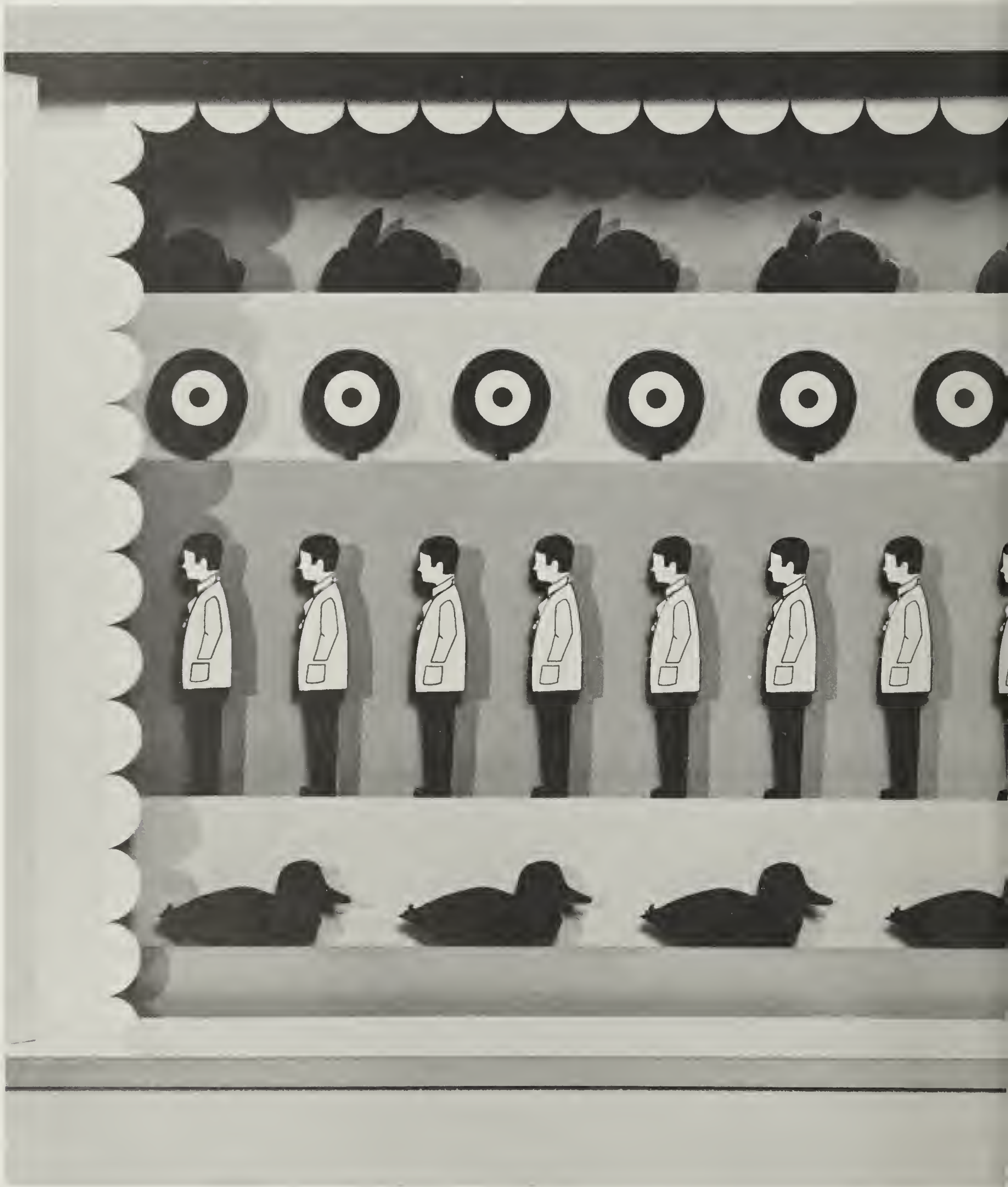

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Liaison Committee with Michigan Department of Public Health

The Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern.

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Committee on Maternal and Perinatal Health

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

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Medicaid Liaison Committee

The Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

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Sherry N. Wellman, Staff Assistant

Task Force on Medical Care Costs

The Task Force considers and evaluates methodologies for containing the cost of quality health care, encourages cost awareness, and develops cost effectiveness information for the practicing physician. It interfaces with the BCBSM Regional Cost Committees, acts as a liaison committee to physicians serving on these committees and reviews cost containment initiatives by the RCCs. The Task Force publishes articles on cost containment in *Michigan Medicine.*

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The Advisory Committee assists the Section in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing, and health delivery systems.

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Committee on Medical Staff Relations

This Committee is working to develop a specific mechanism for interacting with hospital medical staffs and to strengthen and enhance the mutual communications of MSMS and its medical staff leader members.

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Robert W. Black, MD, Detroit
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Devendra Sharma, MD, Tawas City
John C. Sullivan, MD, Port Huron
William E. Madigan, Staff Assistant

Committee on Membership Recruitment and Retention

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to The Board of Directors and conducts personal recruiting efforts when needed.

Billy Ben Baumann, MD, Chairman, Pontiac

Continued on page 714

Michigan Conference on Maternal and Perinatal Health

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This Task Force reviews existing and proposed insurance benefit programs for MSMS members and makes recommendations to the Board of Directors.

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Michigan State Medical Society/ Michigan Hospital Association Liaison Committee

This formal Liaison Committee is composed of designated leaders of the two organizations. The Liaison Committee does not make policy for either organization; each organization refers any recommendations to the MSMS Board of Directors or MHA Board of Trustees for approval.

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James H. Tisdel, MD, Port Huron
Louis R. Zako, MD, Dearborn Heights
Warren F. Tryloff, East Lansing
William E. Madigan, Staff Assistant

Committee on MSMS Policy Manual

This Committee reviews actions of the House of Delegates and incorporates any policy decisions made into the Policy Manual of MSMS.

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Leland E. Holly II, MD, Muskegon
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Kenneth J. Ray, MD, Trenton
Vada L. Davis, Staff Assistant

Advisory Committee on Office Automation

This Committee advises staff in its development of a plan for necessary automation of MSMS office operations.

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Jack L. Barry, MD, Saginaw
Leland E. Holly, II, MD, Muskegon
Robert E. Paxton, MD, Fremont
Vada L. Davis, Staff Assistant

Planning Committee for 1984 Michigan Conference on Maternal and Perinatal Health

The Planning Committee, under the guidance of the MSMS Committee on Maternal and Perinatal Health, plans and implements Category I CME program for the Annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several participating organizations.

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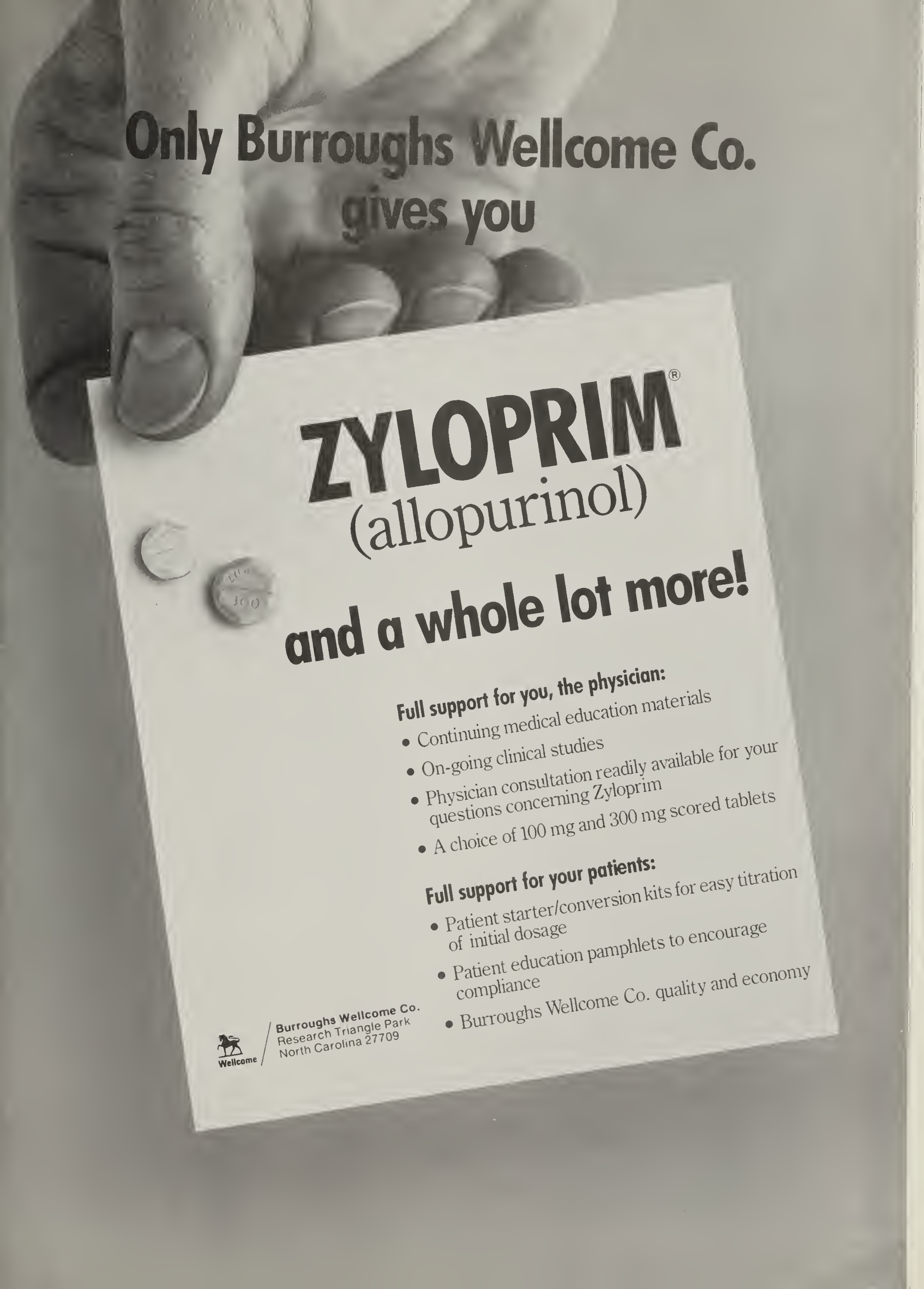
Continued on page 716



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NEWS

By Sheri W. Greenhoe
East Lansing

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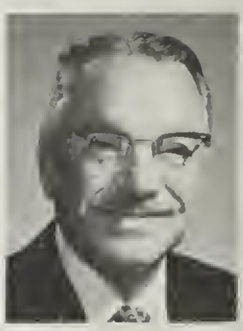
Slagle

Lloyd H. Smith, MD, Ludington, was honored recently for his many years of service and compassion to the citizens of that city. October 14 was designated "Doctor Lloyd H. Smith Day" at Memorial Medical Center of West Michigan. . . . MSMS past president **George W. Slagle, MD,** Battle Creek, received the Laureate Award, granted by the Michigan Chapter of the American College of Physicians for longstanding membership, excellence in medical care and service to the profession and community. . . . **Bill Brooks, MD,** formerly of Texas, is new Oakland County medical examiner. . . . **Henry Domzalski, MD,** Detroit, was named to the Michigan Hospital Association task force on care for the poor. . . . **Harold A. Oberman, MD,** medical director of U-M Hospital's blood bank, has received the American Association of Blood Banks 1983 John Elliott Memorial Award for his outstanding service to the organization. The award particularly recognizes Doctor Oberman's accomplishments as chairman of a committee that influences blood bank practices worldwide. . . . Newly elected officers of the Michigan Occupational Medical Association are **William J. Miller, MD,** Ford Automotive Assembly, president; **Jack E. Benkert, MD,** GM Truck Assembly, president-elect; **Robert S. Rhodes, MD,** GM Hydramatic, vice president; and **Howard J. Sawyer, MD,** OccuMed Associates, Inc., secretary-treasurer. . . . **Perry Rawson, MD,** Addison, recently retired at age 77 after practicing medicine for more than 40 years. He practiced in the town of Addison for the past 11 years, and served as the high school team doctor for eight of them. . . . **Stanley Dudek, MD,** and **James Z. Cinberg, MD,** both of Lansing, were named board members of the Ingham County unit of the American Cancer Society. . . . **W. Michael Bremer, MD,** Kalamazoo, was named director of clinical investigation in Upjohn's Division of Medical Affairs. Units reporting to Doctor Bremer are responsible for the organization and administration of the division's worldwide clinical research program. . . . Jackson oncologist **John A. Axelson, MD,** has accepted the volunteer post of medical director of Hospice of Jackson. **Dennis M. Joy, MD,** Charlevoix, has been appointed medical director of Charlevoix County Hospice, Inc. Both doctors will act as consultants to hospice patients' personal physicians, and will meet with volunteers about pain and symptom control. . . . **R. Leonard Carefoot, MD,** Marquette, recently retired after 24 years of medical practice in that city. Doctor Carefoot is a pathologist, and served as medical examiner for almost 20 years. . . . **Douglas A. Sargent, MD, JD,** Grosse Pointe Farms, recently addressed the First International Conference on Psychological Child Abuse at the University of Indiana. He spoke on medicine's response to the problem. . . . **Linda Logsdon, MD,** Southfield, was appointed to a second three-year term to the American Psychiatric Association Scientific Program. She also has been appointed to the APA Mead Johnson Fellowship Committee for 1983-86. . . . New officers of the West Michigan Chapter of the Michigan Psychiatric Society are: **Walter Grabowski, MD,** Kalamazoo, president-elect; **David Sprague, MD,** Allegan, councilor; **Jack W. Carr, MD,** Grand Rapids, president. . . . **Sheldon Siegel, MD,** West Bloomfield, member of the Michigan Psychiatric Society's Health Care Economics Committee, addressed the Ad-Hoc Committee on Health Care Cost Containment in the Michigan House chambers recently. . . . **Gardner Quarton, MD,** Ann Arbor, was named a Special Award recipient by the Mental Health Association in Michigan. He was cited for outstanding leadership in mental health research, and extensive community involvement. . . . **James L. Abelson,** University of Michigan medical student, is one of 25 students named 1983 Rock Sleyster Scholars. Each student received a $2,000 grant for the 1983-84 school year from AMA-ERF. . . . New president of the American Fertility Society is **Edwin P. Peterson, MD,** of Ann Arbor. Doctor Peterson was among the pioneers in using fiber-optics in the treatment of infertile patients.

Ms. Greenhoe is editorial secretary for *Michigan Medicine.*

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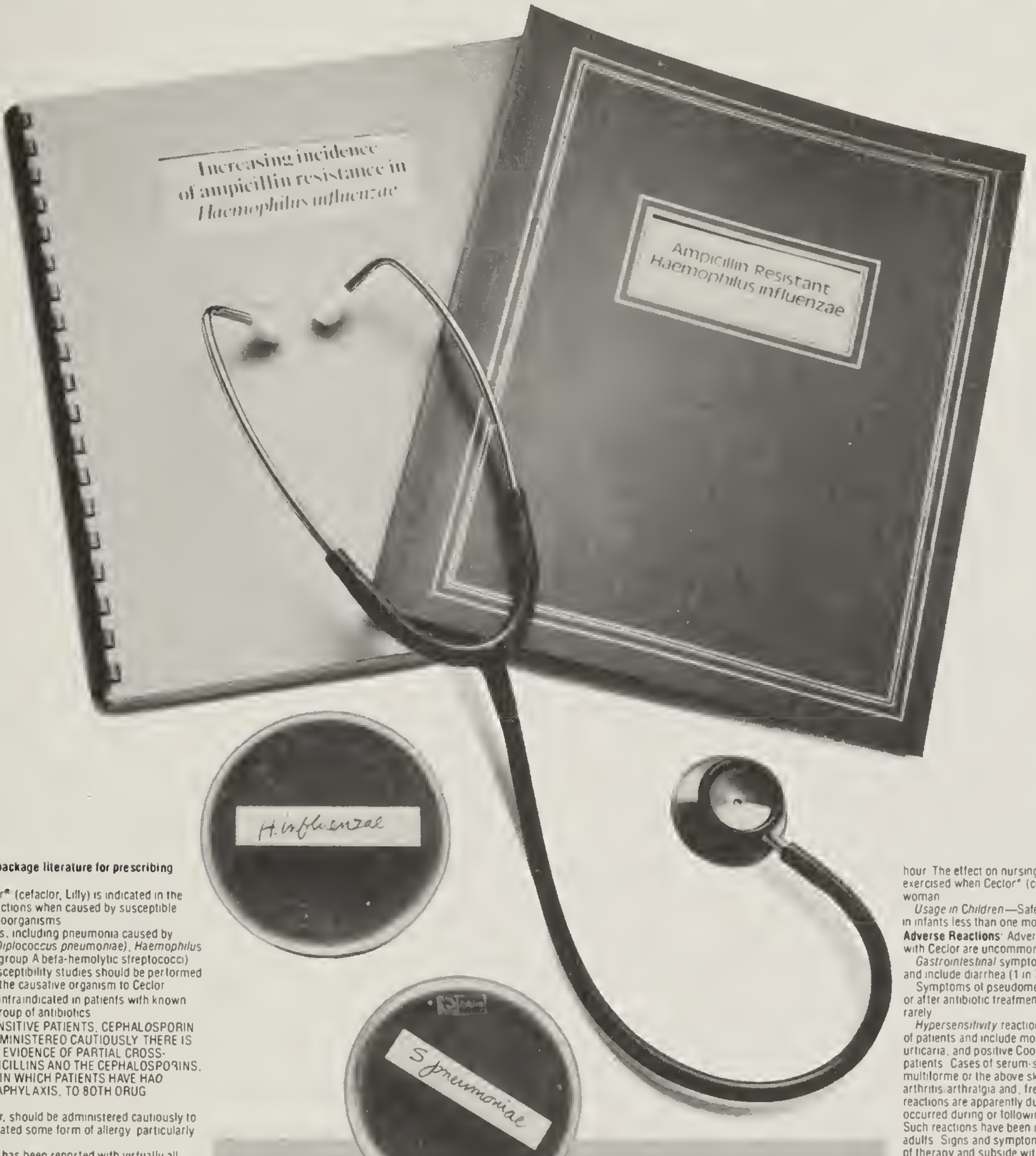
An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
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S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

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8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

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MSMS conference speakers debate quality, cost of health care

By Carole Eberly
East Lansing

Fred E. Patterson, MD, Ann Arbor, chairman of the 1983 MSMS Public Affairs/Leadership Conference, sits front and center in the crowd gathered for the popular annual event. To his left in the front row is morning speaker John C. McCabe, president, Blue Cross Blue Shield of Michigan. Over 250 persons attended the conference.

Persons concerned with the length of life also must be concerned about the quality of life, Agnes Mary Mansour, PhD, told physicians at the MSMS Public Affairs Leadership Conference in October.

Doctor Mansour, director of the Michigan Department of Social Services, said much pressure has been brought on the medical and scientific communities to expand technology in such high tech areas as liver transplants.

"But are we prolonging life with no regard to the quality of life?" she asked the group of about 250.

She asked what the price really was to pay for this new technology.

"When there are limited resources, there are tradeoffs," she said.

She explained that Michigan welfare recipients now receive about $5 per day per person to pay for food, clothing, shelter and warmth. Any money diverted to medical expenses must come out of that $5.

She said health care costs in the Social Services budget have doubled every year since 1965.

"That means we can provide less and less for other areas," she said.

Doctor Mansour said the growth in medical costs is impinging on the ability to meet other basic needs.

She said her department is looking for ways to cut its share of money going to Medicaid by requiring second opinions, shortening the length of hospital stays and supporting HMOs.

Doctor Mansour said her department is prepared to implement recommendations from its new Medicaid Task Force, created to come up with long and short-term solutions to rising costs.

She said the department would not continue to support rising health

Continued on page 722

Ms. Eberly is a Lansing-area freelance writer.

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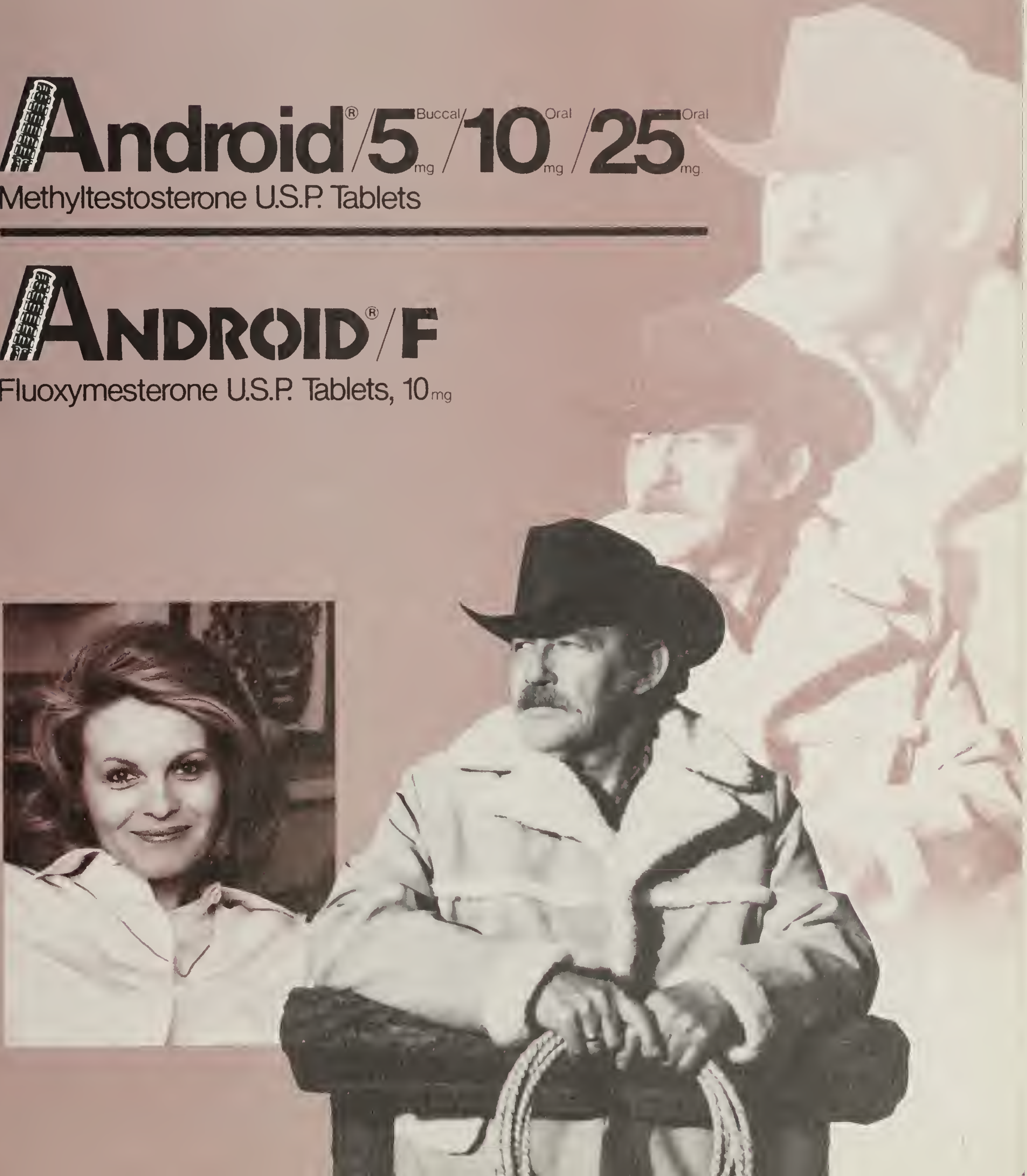


Do you know

a physician with problems of alcoholism, drug abuse, emotional illness or other difficulties which interfere with his or her ability to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY 18 66

Department of Social Services Director Agnes Mary Mansour, PhD, stops to chat after delivering her MSMS Public Affairs/Leadership Conference address.

care costs to the detriment of other basic needs.

Time running out

Another speaker calling for some controls in spiraling health care costs was Walter B. Maher, director of Employee Benefits and Health Services for the Chrysler Corporation.

For every car that rolls off the assembly line, $600 of the price tag goes to pay for health care," Maher said.

He said the continual rise in these costs is jeopardizing American auto companies' ability to compete in the world market.

He blamed much of the increase on the comprehensive package of benefits workers now have along with little or no sharing of costs by the worker. With the elimination of incentives for workers to find less expensive health care, there is no reason for a lid to be put on costs.

"We've effectively eliminated price competition," he said.

He said if some form of cost-sharing were implemented, the volume of persons seeking expensive medical treatment from physicians and in hospitals would go down.

"As long as first dollar coverage continues to predominate, there won't be a prayer of cost containment," Maher said.

"There must be some type of program in operation where if people want to opt for more expensive care, they pay for it," he added.

Now, Maher said, persons believe they have the right to seek any kind of medical care at any cost because they don't see the bills.

He also laid the blame for increasing costs at the doors of hospitals.

"Hospital policies must change," he said. "The development of continuity among hospitals is the only way to get at the problem."

For instance, he said a check by Chrysler with Ann Arbor hospitals showed policies for handling dilatation and curettage patients varied from requiring all patients to stay in the hospital for two days to having physicians perform the operation on an out-patient basis.

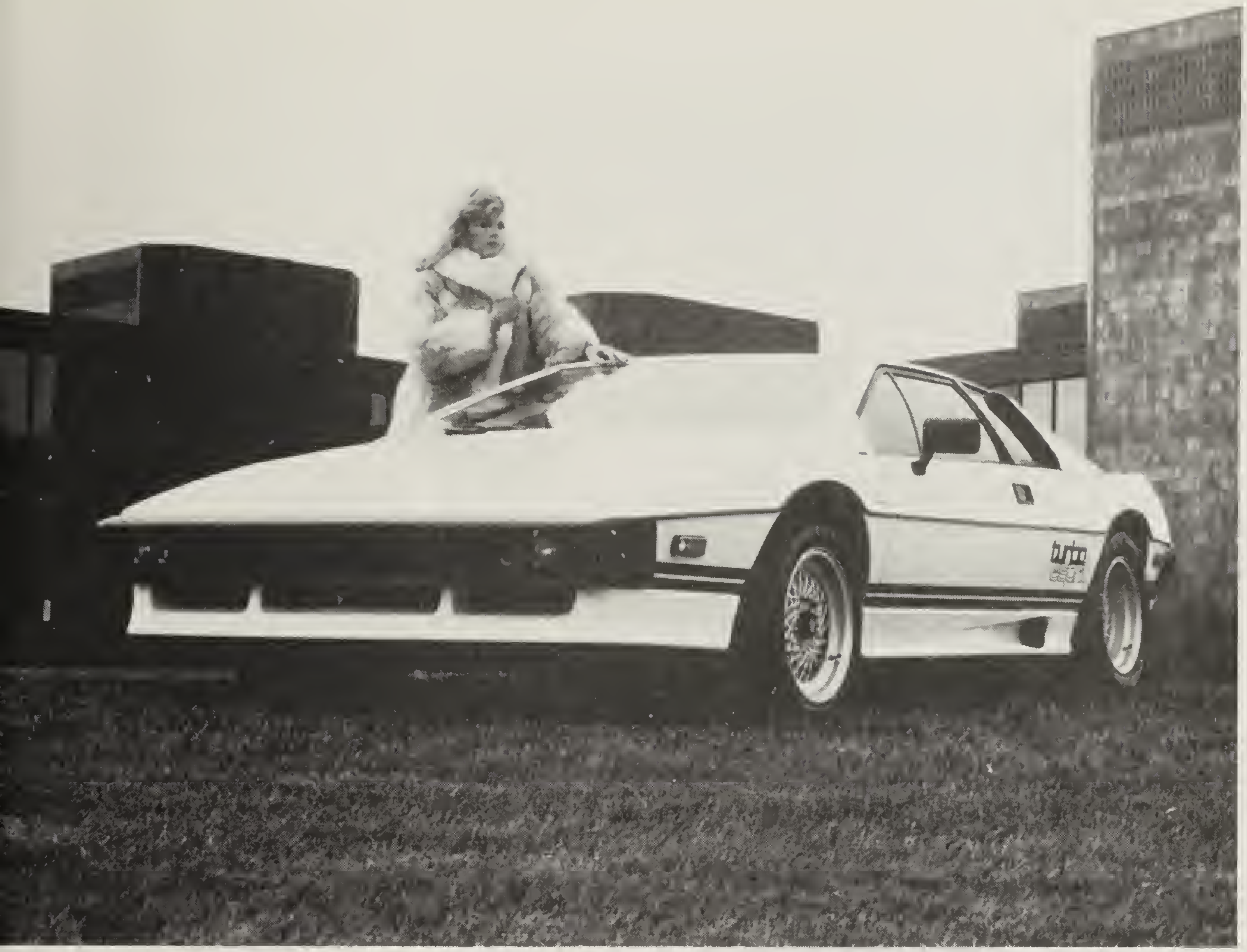
"Competition is what made this country great," Maher said. "And we need more of it in the health care field; because in the absence of competition, you have increasing costs.

"We're not just running out of time," he added. "Time already has run out."

Changes needed

In agreement with Maher on some points was Michigan House Insurance Committee Chairman Matthew McNeely.

Continued on page 724



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MSMS President Donald K. Crandall, MD, right, thanks Public Affairs/Leadership Conference speaker Rep. Matthew McNeely for his presentation.

"The third party payor system isolates the user," he said. Patients really don't care about costs because they never see them.

While he said the legislature is working on such short-term goals as making the consumer more accountable by imposing deductibles, it also is looking at longer term items such as health care education and illness prevention.

"Change is needed, and changes there will be," he said.

The chairman of the AMA Council on Medical Service criticized government imposition of such rules as single national payment schedules.

"Hospitals will learn to play the rules of the new game," said Lonnie Bristow, MD, San Pablo, CA.

For instance, he said, instead of long hospital stays, hospitals could simply make two admissions and file two DRGs for one case.

However, Dr. Bristow said, it is imperative for physicians to maintain their professionalism in the midst of all this change.

"If we ever have complicitness with hospitals to maximize profits, we will lose the confidence of the patient," he said. "Our professionalism will be gone."

Doctor Bristow also questioned whether it was just a matter of time before national payment schedules filtered into the business sector where auto and computer companies would be required to charge one set price for their products. He also was skeptical that the national payment rate would accomplish its purpose.

"What's so magic about a single rate?" he asked.

Like the other speakers, Dr. Bristow said much of the current trouble comes from first dollar coverage.

"Medical services are highly sought after," he said. "More and more the third party payer is looked to for full payment. As a result, the patient and physicians become isolated from costs."

Blame for costs

However, a spokesman from the United Auto Workers, rejected the first dollar coverage argument as inflationary, saying "a cost shift (to the employee) is not cost containment."

"It doesn't deal with the root causes of inflation," said Patrick Killeen, Senior Health Care Consultant.

"I don't have any one villain theory," he said. "There are just toc many factors involved."

Technology was one factor, he said.

"Medical science has developed miracles which save and improve lives," Killeen said. But where will it stop and how many more dollars will be spent, he asked?

He also blamed the lack of a national health plan for rising costs. He said the focus should be on HMOs, second opinions, federal guidelines for costs, and preferred provider legislation.

Physicians at the day-long conference also heard speakers on:

— PROM (Physicians Review Organization of Michigan) Frederick Van Duyne, MD, Flint, said if physicians don't implement a peer review procedure "there are people waiting in the wings to do it," including government, insurers and hospitals.

— PPOs (Preferred Provider Organizations) Mitchell Rinek, MD, Lansing, said the purpose of these is to provide access to care, insure quality care, and control costs. "If you think you can hold back this tidal wave, it's already washing over our heads," Doctor Rinek said.

— Malpractice. Charles Vincent, MD, Detroit, of the MSMS Task Force on Liability, said a number of recommendations have been made to amend malpractice legislation this year.

A few of the changes would limit non-economic (intangible) losses to $50,000; allow periodic payment in damage suits of more than $50,000 to avoid windfall payments; ensure the quality of expert witnesses by requiring physicians witnessing to practice at least three quarters of the time, eliminating so-called professional witnesses; and allow juries to be told if the person bringing suit is already receiving other compensation for the same complaint.

— Joint Venturing and Contractual Relationships. Jay Harness, MD, Chelsea, said there is a 40 percent increase in physicians coming into the market, resulting in "a big scare." Everyone wants to know what's going on," he said. Doctor Harness said now is the time for physicians to maintain their composures and not "make deals on your own" which could lead to legal complications. "Now is the time we should all work together," he said.

Other speakers at the conference included Jerry C. Rosenberg, MD, chief of surgery at Hutzel Hospital, who spoke on marketing strategies for physicians, and John C. McCabe, president, Michigan Blue Cross and Blue Shield, who described why BCBSM is asking for permission to become a mutual insurance company.

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MSMS/A

Michigan auxilians get leadership training

By Betty Drew
Bloomfield Hills

Confluence has been defined as a coming together of people or things; a throng; an assemblage; communication; reunion.

To the 10 county auxiliary presidents-elect from Michigan who participated in the AMA Leadership Confluence, October 9-11 in Chicago, it was all of these and more. Instituted in 1975 by the AMA Auxiliary, this meeting is held annually, to provide leadership training, program seminars, and discussion groups for county auxiliary presidents-elect, numbering more than 250.

Also present were state auxiliary presidents, presidents-elect, and membership chairmen who attended sessions and workshops devoted exclusively to situations and/or problems common to their offices.

John J. Coury, MD, Port Huron, chairman of the AMA's Board of Trustees, was the keynote speaker. He stressed the importance of the physician's spouse as a national, state and local resource for the medical profession as a whole.

"I salute you for your programs, your activities, and, most of all, for your results," said Doctor Coury.

Many of the seminars presented were potential community action programs, on subjects including effective parenting; prevention of child and drug abuse, and the influence of video games and computers on children.

Comments from Michigan auxiliary participants included "stimulating, informative, enriching;" "a sense of belonging to a vital, dynamic organization which can work together to effect health care;" "an opportunity to know our own state members better."

Each state had on exhibit workbooks, bylaws, newsletters, membership tools and projects. The new MSMS Auxiliary membership brochure received many compliments.

Confluence participants will be sharing their experiences at county and district meetings, striving to impart their enthusiasm, knowledge and training to other Auxilians, to insure a productive new year.

Mrs. Drew is MSMS/A president. For more on auxiliary activities, please see page 728.

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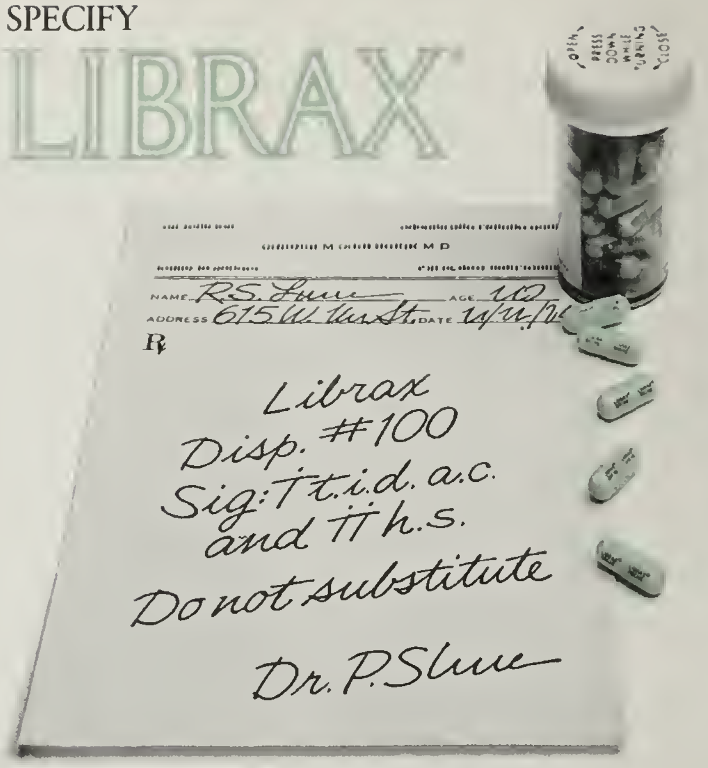

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MSMS/A/*Continued*

Education: Cornerstone of legislative action

By Lillian Fields
Parma

Two of the most important responsibilities of both state and county auxiliary legislation chairmen are to educate members on legislative issues and to motivate them to act on these issues.

In order to educate auxilians about legislative issues facing the medical and health care field, several innovative programs will be instituted this year. The most comprehensive of these will be a "bill of the month" campaign. Each month every county legislative chairman will present either a House or Senate bill which is of immediate concern to the medical society. The twofold goal is: (1) to raise awareness about legislative issues by having regular legislative information at each auxiliary meeting and, (2) to study the main issues in depth, one at a time. In the initial phase of this program, state issues will be presented, with plans to expand to federal issues if the demand develops. One county medical society (Jackson) will be piloting this program with the auxiliary to test its reception with physicians.

Top 10

To supplement the "bill of the month" program, each *Auxilium*(the state Auxiliary newsletter) will feature a "top 10" legislative issues list. Ten top priority issues of organized medicine (five state and five federal) will be listed.

Another new educational program to be offered this year will be statewide sessions to teach county legislative chairmen how to lead and organize legislative programs in their local auxiliaries. These "back to basics" training programs will offer a clearer concept of the legislative chairmanship, practical instructions for organizing legislative alert systems, development of good working relationships with legislators and methods to educate local members on essential legislative news and the legislative process.

Scales tip

Other statewide educational opportunities that have been successful in the past are available again this year, namely, Legislative Day and the MSMS Public Affairs/Leadership Conference. Legislative Day, with its annual informational format, will be held March 28, 1984, at the Civic Center in Lansing. The MSMS Conference took place on October 27, 1983, at Long's in Lansing.

As Auxilians we are striving to make education the cornerstone of our legislative action. Informed involvement is our mandate, our challenge, and our responsibility. For it truly is "Up to Us!"

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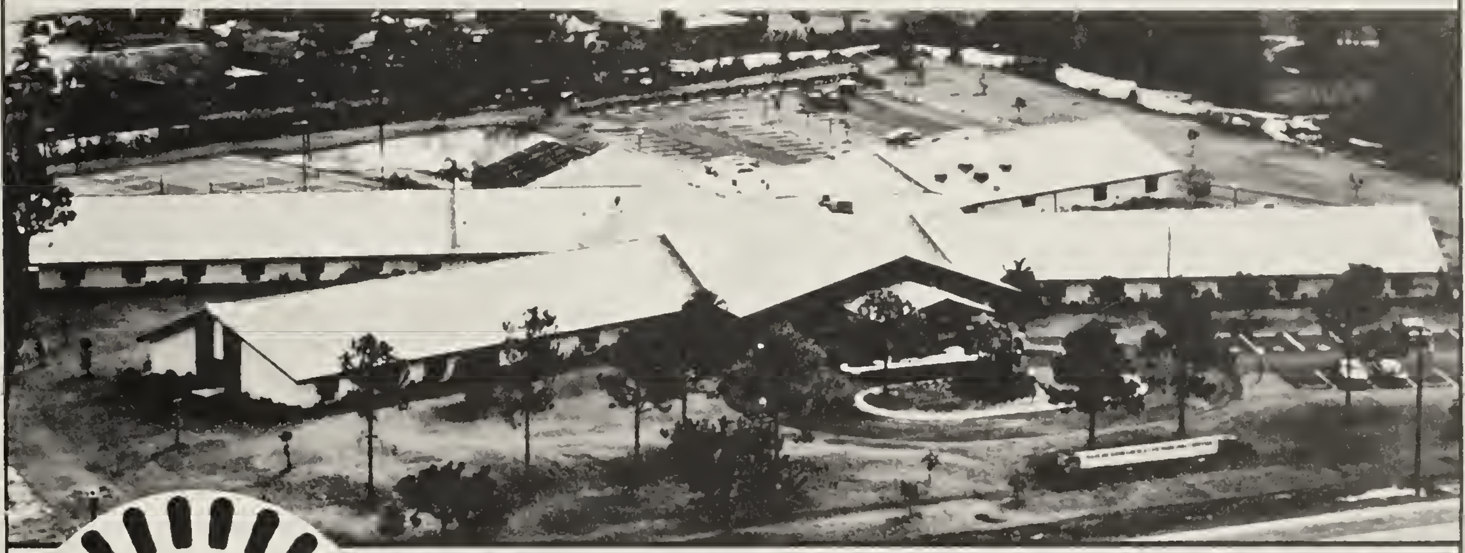

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PPSP having an effect on utilization rates

By Sally Hetrick
Detroit

Cost containment, DRGs, case management, PPO, capitation, innovation, HMO, alternative reimbursement — these are just a few of the buzz words and acronyms floating around health care circles these days.

For some time, health care costs have been rising steadily despite a leveling out in the rest of the economy. Consequently, health care administrators, bureaucrats and entrepreneurs all have been taking a hard look at the health care field and at ways of putting a lid on costs while maintaining services.

The State of Michigan has been heavily involved in the cost containment process. Much of the focus has been on Medicaid costs, which continue to be a major expenditure, often requiring controversial transfusions from other areas such as education and corrections.

In an effort to share the responsibility of the situation and the solution, the legislature in 1981 requested the medical societies to propose an alternative to the traditional fee-for-service method of physician reimbursement. After several months of hard work, the medical societies' task force proposed the Physician Primary Sponsor Plan. The legislature accepted the proposal and charged the Department of Social Services with implementation.

Sally Hetrick is co-project director of the Physician Primary Sponsor Plan. She is a senior departmental analyst for the Medical Services Administration, Department of Social Services. Ms. Hetrick has a bachelor of social work degree from Michigan State University.

PPSP features

The proposal, as outlined by the societies and developed by the department and the project's Steering Committee, contains the following features:

1. Physicians contract with the department to be physician sponsors.
2. Medicaid recipients enroll with a physician sponsor.
3. The sponsor performs case management services by either providing or authorizing most primary care services.
4. Physicians are paid fee-for-service, but sponsors receive an additional $3 per month per enrollee as a case management fee (there is a $3,000 per month maximum).
5. Sponsors maintain a 24-hour availability, either personally or through coverage by another medical care provider.
6. Utilization reports are provided periodically to assist the sponsor in case management.
7. Continued participation is partly determined by the cost effectiveness of the sponsor.
8. If an enrollment is not satisfactory, either the recipient or the sponsor can request a change.

The necessary waivers of federal regulation were acquired, Wayne County was selected as the pilot area and physicians were contracted. Enrollments began July 1, 1982 and have slowly grown to 21,982 for November of 1983. A total of 1,089 physicians have enrolled recipients.

Now we are exploring methods of effecting a higher level of enrollments. Starting January 1, the department expects to broaden the method of enrollments, so that Medicaid recipients may enroll with their physician/sponsors and through their local Wayne County DSS caseworkers. The goal is to have enrollment total at least 150,000 by this time next year.

Early results

How is the program working? It's still too early to make any broad generalizations, but early indications are that the program is having an effect on utilization. Not unexpectedly, some problems also have surfaced. Some of these, like the slow enrollments, are outside the control of the individual sponsor. Physicians' actions have a significant impact on other things.

We can't stress too much the importance of the physician reading the sponsor contract and being fully aware of the responsibilities therein. A recipient enrolled with a sponsor is in a much different circumstance than the recipient with an unencumbered Medicaid card. The sponsor who has not made provision for 24-hour coverage places both the enrolled recipient and the treating provider in a precarious situation. The recipient, especially, can be placed in an anxiety-producing and possibly health-threatening situation when, in keeping with the policies of PPSP, he or she tries to reach the sponsor for advice, treatment or authorization and can't.

Likewise, physicians who move or abruptly leave their practices are potentially disrupting the health care of their enrollees. At the very least, these physicians are creating an awkward transition situation. Adequate notice allows time for us to notify recipients and change their enrollment.

Physicians who treat Medicaid recipients but elect not to contract as a sponsor place their patients in the position of having to change doctors. To be really effective, the plan would like to contract with all Detroit area primary care physicians.

The concept of case management is relatively new and still unfamiliar to many physicians. Implementation of PPSP will be an educating experience for all involved — physicians, other providers, recipients and third party payers. Tools such as utilization reports, bulletins and newsletters will be helpful. Comments on the needs of the sponsor are equally important.

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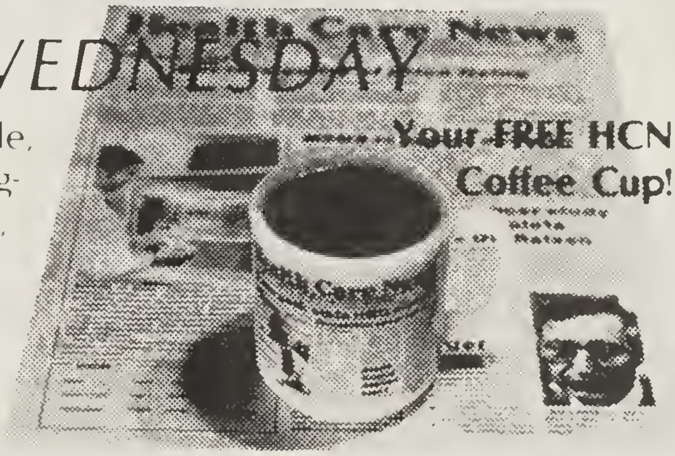

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MEDICAL NEWSFRONTS

University of Michigan researchers reported in a recent issue of *Science* magazine results of a study representing "a step along the way to understanding how the **inner ear works,"** according to Alfred L. Nuttall, PhD, U-M associate professor of otorhinolaryngology.

Commenting on the research report, Doctor Nuttall explained that this is the first time investigators have been able to demonstrate, in the intact and normal mammalian ear, that one of the two types of inner ear receptor cells — the cells that respond to sound waves — can influence the other. They were able to restrict stimulation to only one type of cell and then record the response in the other population of cells.

The long term goal of the Institute is to understand the causes of hearing and vestibular loss so that preventive measures can be developed and restorative procedures can become practical. Knowledge of how the ear functions normally is the first step toward understanding what is going wrong in hearing loss, Nuttall said.

Students at Michigan State University's College of Human Medicine are learning how financial difficulties and other **family crises** can sabotage good health. It's all part of the MD curriculum there.

"Families are nearly always in a state of flux, and it is important for physicians to recognize family vulnerabilities and their potential for undermining good health," says Roy J. Gerard, MD, chairperson of MSU's Department of Family Practice.

First-year MD students at MSU learn about typical crises — having a first child, moving to a new community, living with chronic illness, living with emotional stress, having an older child moving from home for the first time. "These are milestones when families predictably struggle with change and are forced to rework many of their established patterns of getting along with one another and the outside world," Gerard says.

And there is a proven relationship between loss and illness, the students learn.

"This issue of separation is a major one for health care professionals because it is known that in the six to 12 months immediately following a loss, people are more susceptible to physical illness," Doctor Gerard says.

Pontiac and vicinity suffer the highest **unemployment** in the state, experience a high infant mortality rate and have many women delivering children without pre- or post-natal care. These persons are without any health insurance but need free health care, free prescription drugs and free transportation.

Thus, the Oakland Livingston Human Service Agency (OLHSA) provides free health care, transportation and prescription drugs to pregnant women and children up to five years old, if they do not have health insurance, are unemployed, qualify under certain guidelines or are employed but without health insurance.

This free professional health care is provided through St. Joseph Mercy Hospital, Pontiac General Hospital, Lakeside Community Health Center or the person's own doctor (if the doctor agrees to participate).

The program is directed by OLHSA with funds from Blue Cross Blue Shield of Michigan.

Recent studies suggest that patients with **congestive heart failure** not only can tolerate regular, moderate exercise, but in fact may be helped by it.

Researchers at Sinai Hospital of Detroit have received a grant from the Michigan Heart Association to determine how helpful exercise can be. "We already know that exercise helps coronary artery disease patients by increasing work capacity and the level of exertion needed to bring on chest pains or other symptoms," says David A. Wrisley, MD, medical director of Sinai's Cardiovascular Fitness and Rehabilitation Program. "Now we're trying to see if it can do the same for people with congestive heart failure."

Candidates for the study are people with congestive heart failure or severe heart damage. There is no charge for the program, which includes a complete physical examination and cardiologic workup.

Half of the subjects form a control group and will not participate in the exercise sessions, initially. The other half will attend hour-long exercise sessions, which will be held three times a week at Sinai Hospital in Detroit and at Sinai's Nathan I. and Betty Goldin Health Care Center in West Bloomfield.

The sessions will be supervised by a cardiologist, nurse, and exercise physiologist and will include treadmill walking, bicycling, rowing, and other endurance exercise for upper and lower extremity training. Heart rate and rhythm will be monitored continuously. If findings show exercise is beneficial, those who were not in the exercise portion of the study will be invited to participate at a later time.

For more information, call Sinai's cardiac rehabilitation team at 313/493-6333.

The University of Michigan has received well over $1 million dollars in private gifts from U-M Medical School faculty for the University's **Replacement Hospital Project,** officials announced.

A major impetus for the medical faculty campaign was the $100,000 contribution by Doctor and Mrs. Herbert Sloan. Sloan is professor of surgery, head of thoracic surgery in the U-M Medical School and chief of clinical affairs for the U-M Hospitals. More than 40 faculty members made contributions of $10,000 or more.

Doctor Sloan is co-chairman, along with A. Alfred Taubman, of the effort to raise $20 million in private gifts for the $285 million Replacement Hospital Project. The funds are being used to construct a new adult hospital and an adjacent ambulatory (outpatient) care facility and to renovate existing hospital facilities.

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5. The known bondholders, mortgagees and other holders owning or holding one percent or more of total amount of bonds, mortgages or other securities are: None.

6. A. The total number of copies printed averages 9,198 per issue with a single issue nearest to filing date accounting for 9,098 copies.

B. Paid circulation 8,978 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.

C. Sales to dealers, number none.

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COST CONTAINMENT

Let's eliminate those room humidifiers

By Thomas P. Crowley, Sr., MPH

In 1970 Grieble et al reported the infectious hazards associated with the hospital use of so-called room humidifiers. Later in 1977, Smith and Massanari implicated room humidifiers as the source of an *Acinetobacter* bacteremia outbreak which resulted in three deaths at a midwest medical center. These devices had been removed from Sinai Hospital of Detroit in 1972. This action was stimulated by the Grieble study and strongly supported by Sinai Hospital's Infection Control Committee. The committee considered these devices a threat to good patient care.

In 1982, the Centers for Disease Control issued Guidelines for the Prevention and Control of Nosocomial Infections which include a section on in-use respiratory therapy equipment. In this portion it states, "Room air humidifiers that create droplets of humidity (and thus are really nebulizers) should not be used."

Alarming

Yet, it has been estimated by the American Association of Respiratory Therapy that hospitals representing 20 percent of the nation's beds still may use these devices which is surprising — and alarming.

Not only are these devices injurious to patients' health, but they represent an unneeded expense to the hospital.

Based on the data of the surveys mentioned above, the annualized cost associated with the hospital use of so-called room humidifiers is estimated between $20,000,000-$80,000,000. (See attached calculations.) It is difficult to adjust this figure to include the cost related to nosocomial infections generated by these devices. But, we know that:

1. So-called room humidifiers are a threat to good patient care since they enhance the host-agent-environment interaction for causing disease. Permitting these devices to remain in use must contribute to an increased nosocomial infection rate and associated increased lengths of stay which will escalate costs. In view of the proposed DRG system, such a complication would contribute to cost overruns.

2. They present little or no therapeutic value to the patient. In fact, since these devices generate particulate matter, they are really nebulizers and not humidifers. Experiments at Sinai Hospital of Detroit in the mid-seventies indicate a four to six percent increase in relative humidity from these units.

I appreciate the opportunity that the Task Force on Medical Care Costs has given me to present this material on room humidifiers. Perhaps this practice may be perceived as trivial, but when one evaluates the multi-million-dollar costs, the threat to quality patient care and the other health hazards associated with room humidifiers' use, it becomes significant.

Calculations of Annualized Costs to the Nation's Insurance Carriers for Use of Room Humidifiers in Hospitals

Note: These devices are billed as respiratory therapy or respiratory care. They are not billed as environmental enhancements. It is difficult to estimate the number of hospitals using these devices nationally; however, the AART indicates that hospitals representing 20 percent of the national beds make up the users.

Example I

Calculation:

A. 5% hospitals still using room humidifiers

B. Average bed size = 165*

C. Patient population using room humidifiers = 5% or 8.25

D. Based on 75% occupancy, this equals 274 patient days/year

E. 8.25 patients x 274 days = 2260 patient days/year

F. @ $25.00/day = $56,500/hospital/year

G. Extrapolate to national use rate of 5% x 7000 hospitals = 360 x 56,500 = $19,775,000.00

***American Hospital Association, *Hospital Statistics,* 1979 Edition, Chicago, 1979, Table 2A, pp. 8-9 and Table 2B, pp. 10-11.**

Summary

Based on hospital use rates of five percent, 10 percent, 15 percent and 20 percent, the annualized costs to insurance carriers would be as follows:

I.	5%	$19,775,000
II.	10%	$39,550,000
III.	15%	$59,325,000
IV.	20%	$79,100,000

As a critical note, I have drawn some assumptions in making these simple calculations, viz, bed size, patient population, frequency of use. However, in the long run, I believe an institutional sample might find these data conservative. For example, I know of one local 300-bed hospital that uses several cases per week of room humidifiers. Based on my experience as a registered respiratory therapist and hospital environmental health researcher, I would expect the use rate to include five percent to 10 percent of the hospitals.

Mr. Crowley is assistant administrator of Sinai Hospital of Detroit. He formerly was director of respiratory care services.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: January 9-11, 1984, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: January 11, 1984, Infectious Diseases Update. Location: Sheraton Inn, Detroit. **Sponsor:** Henry Ford Hospital, Medical Education Office. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 5.5 hours of Category I Credit.

Date: January 18, 1984, Otorhinolaryngology Update. Location: Henry Ford Hospital Office of CME. **Cost:** $100-practicing physicians; $50 — residents and others. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-3073. **Approved for:** 7 hours of Category I Credit.

Date: February 11, 1984, February Seminar, Michigan Society of Pathologists — "Quality Control in the Clinical Laboratory." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists in cooperation with the Great Lakes Regional Quality Control Program. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint 48503. **Approved for:** 3 hours of Category I Credit.

Date: March 17-24, 1984, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Continental Inn, Aspen, Colorado. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 30 hours of Category I Credit.

Date: April 9-11, 1984, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: April 12-15, 1984, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing, 48824. **Approved for:** 32 hours of Category I Credit.

Date: September 10-12, 1984, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

DOCTOR CRANDALL/*Continued*

charge" to an indemnity system also could save money. It has been suggested that the decrease in level of program reimbursement expected in DRGs could be extended to physician reimbursement as well. An increase in coinsurance and deductibles from the current 20 to 25 percent would result in an average cost-sharing in excess of $1,000 per year. With a greater percent of Medicare dollars going to nursing home care, it was hoped that Hospice benefits would reduce costs. However, this benefit would add $80 million to the Medicare budget in 1984 alone.

The Medicare program was not instituted as a welfare program, but rather as an entitlement. But applying a means test with increased Part B premiums based on income and assets, increased coinsurance based on income and assets, and a tax on the value of Medicare coverage all are ways of securing the solvency of the program.

The last category of solutions falls under the heading of system changes. These are the reforms that would most directly affect the mode of practice of medicine. The first would be to eliminate the freedom of choice provision of the Medicare law. Direct contracting and preferred provider-type organizations would increase competition and decrease costs. Broadening of the DRG-type payment mechanism to physicians' services also would be cost saving. A voucher system, mandatory participation and lists of participating physicians, and assignment incentives also have been discussed.

Magnitude

As you can see, the solvency of the Medicare system is a problem of great magnitude. Unfortunately, solutions such as that proposed by the House Ways and Means Committee Chairman Dan Rostenkowski are not the answer. His provision would require physicians to accept Medicare assignment for all services to hospital inpatients and roll-back physician reimbursement for these services.

Mandatory assignment would eliminate cost awareness on the part of the patient and increase utilization. A roll-back of physician fees would do nothing to save the Medicare Hospital Trust Fund money. The only effect of this proposal would be to move us one step closer to the socialization of the practice of medicine.

Although the Medicare Trust Fund problems are great, they are not insurmountable. However, it will take a major effort on the part of all interested parties to resolve the problem. Sacrifices will have to be made by both the providers and recipients of care. Let us hope that the integrity of the Medicare program, both access and quality, and the integrity of our profession are maintained in the process.

MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

Jan. 18, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Feb. 4-5, 1984 — "Through the Looking Glass," American Association of Medical Assistants, Michigan State Society, Mid-Winter Seminar, Amway Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

Feb. 23-25, 1984 — AMA 1984 National Leadership Conference, "Bold New Directions," Downtown Marriott Hotel, Chicago, contact: AMA, 535 N. Dearborn St., Chicago 60610 (312) 751-6000.

March 7, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

March 28-29, 1984 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

April 12, 1984 — Sports Medicine Conference, Long's of Lansing, contact: Mert Scholten, MSMS headquarters.

April 26-29, 1984 — Annual State Convention, American Association of Medical Assistants, Inc., Michigan State Society, Lansing Hilton Inn, contact: Caroline Rich, MSMS headquarters.

May 4-6, 1984 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact Warren Tryloff, MSMS headquarters.

July 26-29, 1984 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 19, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 21, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other meetings

Jan. 27-28, 1984 — Michigan Psychiatric Society Winter Meeting, "1984 and Beyond: Psychopharmacology," Hyatt Regency Dearborn, contact: MPS, 21700 Northwestern Highway, Suite 760, Southfield 48075.

April 2, 1984 — 63rd Annual Beaumont Lecture, John S. Najarian, MD, Minnesota, Speaker. Contact: Wayne County Medical Society headquarters.

June 14-15, 1984 — Michigan Chapter, American College of Surgeons Annual Meeting: Day 1, Resident Surgeons Day Competition; Day 2, Scientific Meetings. Grand Traverse Resort, Grand Traverse Village, contact: Viola M. Heins (517) 337-1351.

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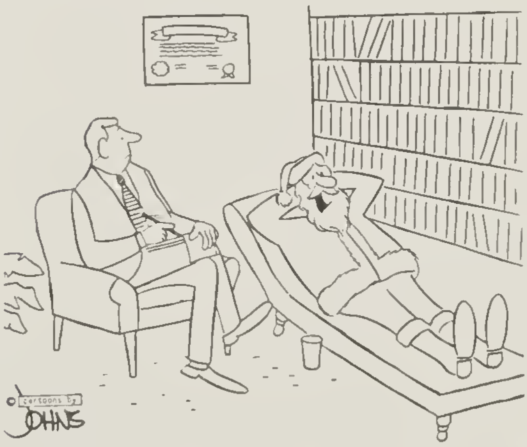

"I love the Yule season. It's the one time of year people don't stand gawking at me."

PRESIDENT'S PAGE

Our greatest challenge: keeping Medicare solvent

By Donald K. Crandall, MD
MSMS president

If there is one challenge facing medicine above all others, that stands between medical practice as we have known it and the total socialization of medicine, it is the challenge of protecting the solvency of the Medicare Trust Fund.

According to the 1983 annual report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, the Part B fund is actuarially sound. However, the 1983 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund indicates that even under the most optimistic of projections the Part A trust fund will exhaust all of its funds by 1996.

Primary reasons

The Supplementary Medical Insurance program (Part B) operates along the same lines as yearly renewable term insurance. It is intended to be self-supporting from premium income and from income contributed from general revenues in proportion to premium payments. The Federal Hospital Insurance Trust Fund (Part A) is principally funded through taxes paid by workers and their employers. In 1982, the HI program covered 26 million people over the age of 65 and three million disabled persons under the age of 65. Income to the fund in that year totaled $38 billion, and total disbursements were $36.1 billion. The primary reasons why the HI fund is projected to go bankrupt sometime in the 1990s are the continued increase in costs for providing Part A Medicare services and the continued increase in the covered population. Depending on whether the view is optimistic or pessimistic, the fund will be depleted between 1988 and 1996.

With the realization that the Medicare program must be revamped to prevent the depletion of the HI trust fund, members of Congress are starting to look at means to prevent or delay the projected depletion. The solutions generally are to (1) increase revenue, (2) decrease beneficiaries, (3) decrease benefits, (4) use a means test, and (5) change the system.

Increasing revenue can be accomplished by increasing the tax rate or tax base, increasing beneficiary costs and/or supplying general revenues, or by designating specific tax revenues for the trust fund. Under current law the health insurance tax is scheduled to increase from 2.6 percent in 1983 to 2.9 percent in 1990. The maintenance of the HI tax rate at a level sufficient to cover projected increases in the program expenditures would result in an HI tax of 7 percent in 2020 and 9.29 percent in 2040. As the population ages, the 5.1 workers per beneficiary in 1960 has dropped to 3.2 currently and is projected to reach a level of two workers per beneficiary by the middle of the next century. The Part B premium was designed to be funded only one-half by general revenues. In 1982 general revenue contributions equaled 75.6 percent of total income. For premium income to equal 35 percent, the current premium of $12.20 would need to be increased to $18.90. It has been suggested that designated tax revenues from alcohol tax, tobacco tax, health insurance tax, luxury tax, and/or income tax surcharge could be used to increase revenue.

Solutions

A second method by which the Medicare program could become more self-sufficient is through a reduction in the number of beneficiaries. The 1983 Social Security Amendments raised the age of eligibility for Medicare from age 65 to age 67 by the year 2022. However, this will not affect the expected depletion of the HI trust funds. As people live longer they use a greater number of services resulting in a significant increase in expenditures. A solution would be a post-retirement employment-based coverage until the age of 70. Reducing the coverage for end-stage renal disease and coverage for the disabled would reduce the number of beneficiaries.

A third method is a decrease in benefits. This could take the form of reduction in benefits of independent practitioners such as chiropractic and optometric services. Moving from a "reasonable

Continued on page 740

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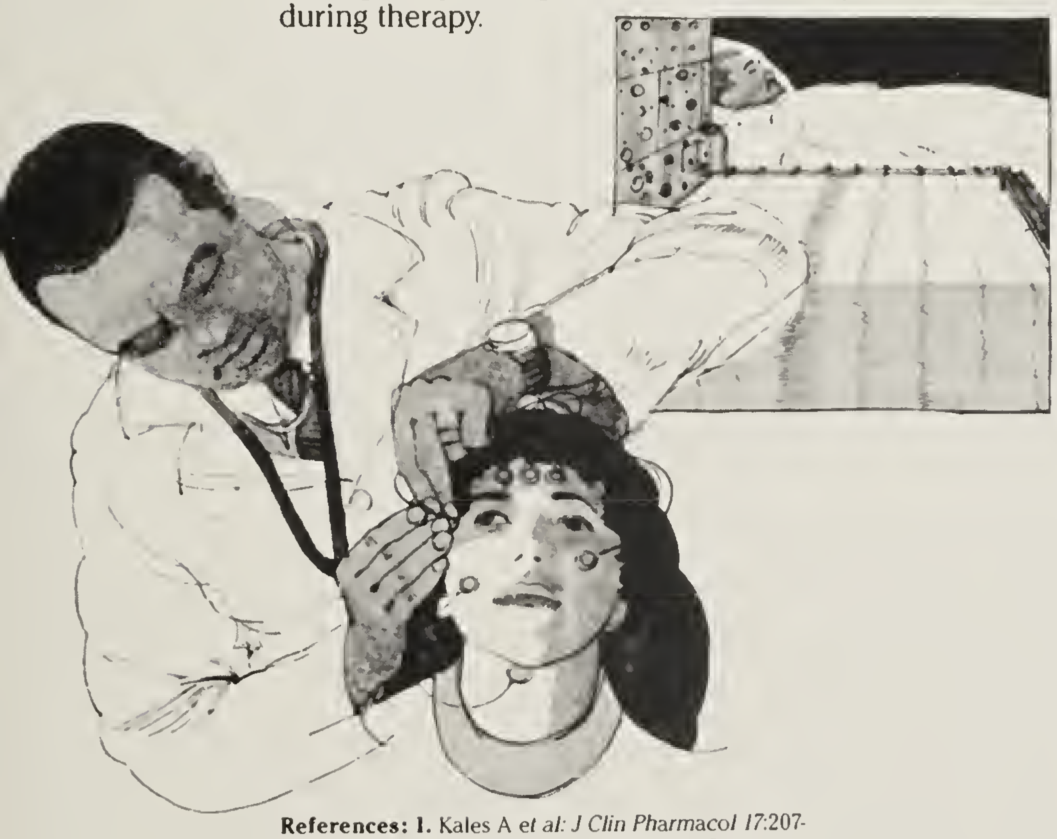

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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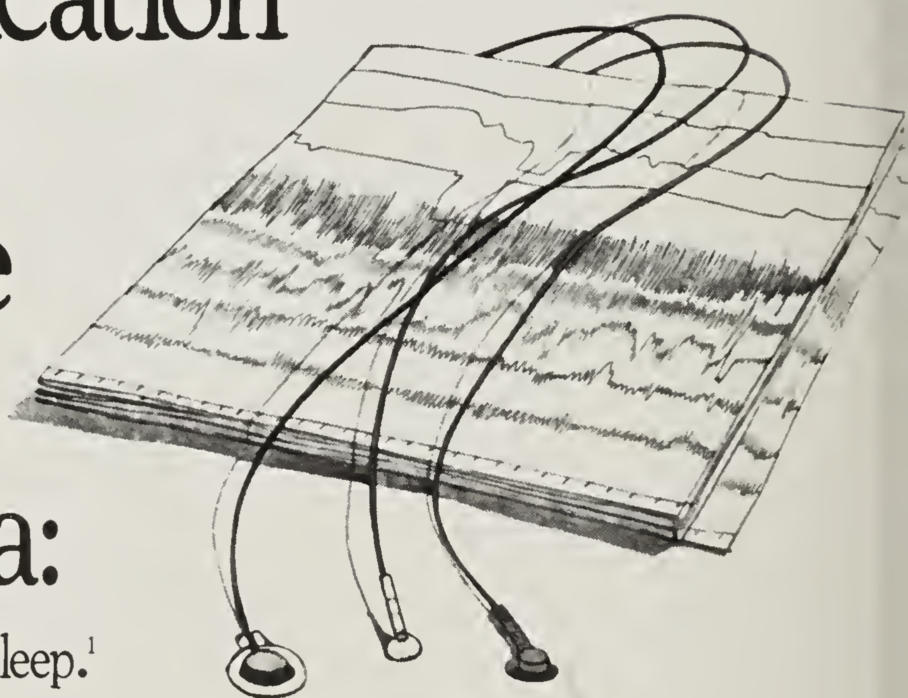

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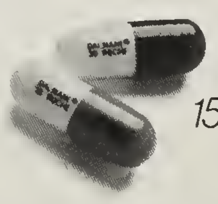

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Vol. 82, No. 58 December 15, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

AMA APPROVES JCAH STANDARDS PROGRESS REPORT

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After extensive debate, the AMA House of Delegates has accepted a progress report on new JCAH standards for hospital medical staffs. MSMS delegates and representatives from Michigan hospital medical staffs joined in the controversy at the Dec. 4-7 Interim Meeting of the AMA delegates in Los Angeles. At issue was expansion of medical staffs to non-physicians, and who should hold credentialling authority in hospitals. The report as approved by the AMA uses the term "medical staff" instead of the more expansive "professional staff" wording of the original JCAH report submitted earlier this year. The latter term was heatedly opposed by physicians around the country.

This was only one of several spirited deliberations in which the MSMS delegation participated. Chairman Richard J. McMurray, MD, Flint, and Vice Chairman Frank B. Walker, II, MD, Detroit, used all 22 of Michigan's delegates and alternates as reports were submitted on professional liability, care for the aging, pluralistic payment systems for health care, and structuring of relationships among the new medical staff sections, their state medical associations and the AMA.

About 50 Michigan physicians were in Los Angeles for the meeting, half of them as participants in the AMA's new section for hospital medical staffs. Gary Maynard, MD, Kalamazoo, chaired the Michigan contingent of hospital representatives; Henry Domzalski, MD, Detroit, serves as secretary of the AMA section, and Peter Duhamel, MD, Rochester, chaired one of two medical staff reference committees. Also present from Michigan were four physicians representing national specialty societies.

Donald N. Sweeny Jr., MD, Detroit, chaired the convention's reference committee on constitution and bylaws, and Robert D. Allaben, MD, Detroit, served on Reference Committee B, which dealt with legislation.

Three major AMA publications won approval of the House of Delegates: one entitled "A Physician's Guide to PPOs," another on DRGs and a third on the environment of medicine in the 1980s.

HEALTH OCCUPATIONS COUNCIL: COMPETENCY ASSESSMENT IMPRACTICAL

The Michigan Health Occupations Council Dec. 12 sent a message to the legislature that in these times of state fiscal strain, continued competency assessment of health professionals is not practical. The HOC thus took a stand parallel to the MSMS Board's. The council recommended to the legislature that the limited resources available to licensing boards, Department of Licensing and Regulation and the Department of the Attorney General should be focused on identifying and disciplining incompetent practitioners through a more effective complaint and investigatory process.

MAOPS MEMBERS TO SERVE ON PROM BOARD

The Michigan Association of Osteopathic Physicians and Surgeons soon will elect four members to serve on the board of the Physicians Review Organization of Michigan (PROM). PROM is the MSMS subsidiary formed to review the appropriateness and quality of medical cases. The MAOPS recently sent the PROM board a resolution endorsing PROM, and bylaws amendments allowing MAOPS to elect four board members (one to serve on the executive committee), to purchase PROM stock and to provide for the number of MAOPS board members to remain proportional to the number of MSMS board members in perpetuity. MSMS expects the MAOPS representatives to join the PROM board at its Jan. 25 meeting.

LOWERING INFANT MORTALITY RATES TASK FORCE GOAL

The Michigan Department of Public Health is beginning a process to determine whether prenatal and postpartum maternity care can be made available and accessible to all in need. A blue ribbon task force appointed by MDPH Director Gloria Smith, PhD, is meeting between now and March 2 to carry out the process. The task force is working under the premise that early and continuing prenatal care is one of the most effective services to prevent low birth weight, infant deaths and other complications of pregnancy. The department is seeking $2.5 million for "prenatal care capacity building." Michigan's infant death rate was 13.2 per thousand in 1981. It dropped to 12.1 in 1982, but still exceeds the national level of 11.2. Among blacks, the infant death rate in Michigan is 21.8. They also experienced more deliveries with little or no prenatal care in 1982, and their low birth weight ratios worsened.

CAPSULES

It is time now to order copies of the 1984 MSMS Roster of Members. The biennial volume, which features by-county and alphabetical lists of MSMS members, is free to every member who requests a copy. Order forms appear in the Nov. 17 and 24 and Dec. 8 issues of Medigram. . . . Harper-Grace and Hutzel Hospitals, two of Detroit's oldest, are merging to form a single corporation. The move is to provide a comprehensive hospital and medical services network linking Hutzel and Harper-Grace with other community hospitals. A primary objective is to develop alternative service plans to be offered to major corporate health care purchasers.

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Vol. 82, No. 59 December 22, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

IT`S TIME TO REAFFIRM COMMITMENT TO PATIENTS

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In this holiday season of reflection and renewal, MSMS presents the following excerpts of a report delivered at the 1983 AMA Annual Meeting in June. Then AMA Chairman Joseph F. Boyle, MD, discussed "Commercialism in the Practice of Medicine" with the AMA delegates assembled in Chicago. His sentiments provide perspective as we plan for 1984.

"Medical practice is at risk of being swallowed up in the concept that the health care industry provides for the health care needs of society. The health care industry, consisting of third party payors, hospitals and all the technology that goes with an industry, provides support for the professional practice of medicine; but the physician should not be thought of nor should he or she function as merely a chief or supervising technician employed by a health center or clinic in an industrial complex. Medicine is a profession, a calling, and not a business or a segment of an industry. Physicians serve patients, not clients, nor customers, nor health care consumers.

"The art of medicine is practiced by physicians concerned with the welfare of individual patients. Commercialism in the practice of medicine would reduce the professional to the level of a technician engaged in assembly line services.

"The Board of Trustees urges physicians to avoid the trap of identifying themselves as part of the health care industry. Physicians serve individual patients first and their self-interests secondarily. This is difficult to convey when the physician is regarded as an important income producer in the profit center of a hospital, or when consideration must be given to the profit demands of stockholders who provide the facilities in which the physician functions and who share in the profits derived from the physician's services.

"Ethical physicians throughout the history of medicine have dealt capably with the conflicting needs of patients and the needs of those who provide the facilities for treatment.

"The Board of Trustees urges all physicians to reaffirm their commitment to the primary mission of the medical profession--taking care of patients. Physicians should be mindful of the threats to medical professionalism, and they should be ever alert that the needs and welfare of patients are placed first in all situations. The commitment of each physician should be that medical care is provided by individual, dedicated professionals devoted first and foremost to providing individual professional services to individual patients. The physician's primary responsibility today, as it has been throughout the history of medicine, is to his or her patients."

Happy Holidays to all MSMS members!

MEDICAID EXTENDS TURN-AROUND FORM DEADLINE FOR MDs

Some Michigan physicians have until March 15 to complete and return their new Medicaid provider "turn-around" forms. The forms were mailed Oct. 28 by the Medical Service Administration of the Department of Social Services, which required that they be returned by Jan. 15. However, some physicians were missed on the first mailing and should receive the forms in January. They will have until the March deadline to return them. If an MD does not receive a form by Jan. 31, he or she may call the Medicaid hotline (1-800-292-2550) or write the MSA, Provider Enrollment Unit, PO Box 30037, Lansing, 48909.

MEDICARE NOW PAYS FOR DIABETES EDUCATION

Medicare has authorized hospitals in Michigan to bill separately for reimbursement of diabetes outpatient education services. Blue Cross Blue Shield of Michigan, the intermediary here, will reimburse education services which meet the following criteria:

1) Are furnished under a physician's order;
2) Are made by the hospital's personnel who are under medical staff supervision;
3) Are provided to individuals who are registered outpatients of the hospital with a diagnosis of diabetes, and
4) Meet the reasonable and medically necessary Medicare criteria of treating a newly diagnoses diabetic or a diabetic whose physician feels that the patient would benefit by attending such a program.

The Diabetes Control Program, Michigan Department of Public Health, will provide hospitals with information on quality diabetes education programs. For information contact 517/373-1356. For questions in reimbursement, contact the Government Provider Inquiry Department at 313/224-8222, or 1-800-482-8760.

PSG OFFERS MDs LEASING OPTION FOR OFFICE EQUIPMENT

The MSMS Physician Service Group, Inc., has endorsed a new service corporation for benefit of MSMS members. The firm is Medi-Lease(TM), which can provide physicians with a lease plan for all equipment, office furnishings and vehicles used by the medical profession. Medical groups, in particular, can reap tax and budget benefits by taking advantage of lease plans. For further details, contact John Anthony at 517/337-1351.

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Vol. 82, No. 59 December 22, 1983

Vol. 82, No. 60 December 29, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

1983 WAS A VERY GOOD YEAR

MSMS members, leaders and staff together accomplished an impressive number of good things in 1983. It was a year which saw:

1) MSMS membership reach the all-time high of 10,600, including over 500 medical students. The MSMS House of Delegates for the first time offered first year free membership to all students.

2) The long-running FTC vs. MSMS lawsuit settled, the outcome much softened after appeal and restrictions on physicians little changed from the pre-trial days.

3) Legislation initiated to enhance present medical malpractice statutes and to thwart another insurance crisis brought on by excessively high settlements.

4) The Physicians Review Organization of Michigan incorporated and a 24 member board of directors selected. PROM now is planning a bid for the Medicare review contract for Michigan, and has two private reveiw contracts with MESSA and BCBSM.

5) A new MSMS resident physicians section developed, and membership increased 400 percent.

6) The "Challenge of the 80s" seminars, booklets and articles developed and presented widely to the membership to help them deal effectively with economic changes.

7) Forty-eight weekly Medigram newsletters and 12 Michigan Medicine magazines published to keep members in touch.

8) The AMA's GTE/Medical Information Network distributorship won by the MSMS Physician Service Group and sales begun to MSMS members to connect them to the network.

9) A new life and disability insurance program planned for physicians and their employees, to be implemented early in 1984.

10) MSMS lobby effectively to modify legislation allowing insurance companies to establish preferred provider organizations, expanding the scope of chiropractic and allowing taxation of free-standing clinics.

11) MSMS educate members through a series of seminars and publications on TEFRA, preferred provider organizations and alternative reimbursement systems.

12) MSMS initiate legislation to provide legal immunity to Board of Medicine members and strongly support bills to make adult seat belt use mandatory.

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14) Created a Committee on Bioethics.

15) Cooperated with the AMA to survey Michigan physicians on their attitudes and experiences regarding child abuse, and formed a committee to educate physicians on the need for involvement in the care of abused children.

16) Become an active participant in the AMA "PADS" project being piloted in Michigan to identify prescription drug diversion.

17) Expanded impaired physician program to include osteopathic physicians and surgeons. The program will be funded through the Michigan Foundation for Medical and Health Education, which is under MSMS aegis.

PPO "NUTS & BOLTS" CONFERENCE SET

MSMS will provide "nuts & bolts" directions for physicians planning joint venture PPOs, at a day-long seminar in Lansing Wednesday, March 14. The conference, sponsored by the MSMS Section on Medical Economics and Reimbursement, will deal with step-by-step advice on how to organize and develop a PPO.

CAPSULES

Jan. 18 is the deadline for the first of two payments allowed MSMS members who chose the installment dues paying option. Those with questions may contact Wayne Burmeister at MSMS headquarters. . . . "Housecall," the MSMS-produced medical progra on Lansing's TV Channel 47, is reaching 56,000 mid-Michigan residents. The latest Neilson ratings give the program a 3 share, th highest of any of the station's public service programs. The program thus is reaching 23,670 homes, which the ratings service figures each have 2.4 viewers tuned to the program. . . .James Fenton, MD, Bay City diagnostic radiologist, is the new chairman of the Michigan Board of Medicine. Doctor Fenton was elected to succeed Donald Kuiper, MD, Lansing gastroenterologist. Continuing as vice chairman of the board is Charles Vincent, MD, Detroit obstetrician-gynecologist.

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